

THE BODY AND THE WORD

A Direction for Psychotherapy

George Downing

George Downing, Ph.D.
9, Villa Ste. Foy
92200 Neuilly-sur-Seine
France

Telephone: 01/47225489
Fax: 01/47220950

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INTRODUCTION

What is the body? This question has come to haunt our era as it has no other in history. In recent years a number of philosophers, feminist theorists, literary critics, historians, anthropologists and sociologists have sought to discover where its threads might lead.¹ Common to their inquiries has been a conviction that what biology and chemistry can tell us about the body falls short. The physiological substratum of my body is one thing. But what I experience in inhabiting my corporal home is a body with interiority, subjectivity, and a sense of agency. The late French philosopher Maurice Merleau-Ponty liked to call this the "lived body". Like time, it is totally familiar and totally strange. So pervasive is its presence we tend hardly to notice it. Yet it puts its silent stamp upon everything we do.

In my own field, psychotherapy, this theoretical question of the body has received surprisingly little discussion. That lack

¹For example, in philosophy Dreyfus (1991, 1992), M. Johnson (1987, 1993), Leder (1990), O'Shaughnessy (1980), Taylor (1993) and Todes (1963), all writing partly in the tradition of Merleau-Ponty (1962, 1963, 1968); in feminist theory Bordo (1993), Butler (1993) and Grosz (1994); in history Gallagher (1987) and Laquer (1990); in literary theory Scarry (1985); in anthropology Csordas (1994); and in sociology Bourdieu (1977, 1990).

is all the more puzzling in that the body has indeed become an object of attention on a technical level. Much more than was the practice in previous decades, many therapists today encourage patients, in a variety of ways, to speak about their bodily experience. A growing minority of therapists also use "body interventions" along with the traditional verbal exchange. This means that patients are helped to explore and sometimes alter certain breathing patterns, postures, muscular tightenings, etc., such that increased inner contact with the body is made possible.

In short, the technical repertoire as far as the body is concerned has undergone a considerable expansion. But on the level of theory? There the conversation one would expect to be taking place has hardly begun.

What, for example, should be the purpose of having patients become more aware of their bodies? Of having them find words for this awareness? Where should these words come from, and how should they be understood? What might it mean for patients to transform how they live their bodies? Transform in what direction, according to whose norms, employing what means? If the patient's body undergoes metamorphosis, what are the consequences for the exploration of memory? What are the consequences for the transference (how the patient feels towards the therapist)? What are the consequences for the countertransference (how the therapist feels towards the patient)? These are issues which, as will be seen in these pages, radically change their hue and cast according one's theory of embodied mind. Yet they have rarely been approached on that level.² Perhaps more importantly, even

²I don't mean that therapists don't discuss the aims and rationale of having patients become more aware of their bodies. They do, and fruitfully (e.g. Perls, et. al. 1951, Kepner 1987). Such discussions are seldom combined with a

the intellectual framework which might set the context for this dialogue has been missing. •

The present book is intended as a step towards making such a framework available. I have taken up two interrelated concerns. The first is to describe a particular therapy methodology, one which I have been developing over many years and which includes "body interventions". The second is to offer some proposals about the nature of the body -- the "lived body" -- itself. This I undertake partly by discussing what many patients report themselves experiencing with their bodies in therapy. I also give an account of some of the most interesting findings from recent experimental research into infant development, and show a number of parallels between these results and what adult patients experience. Occasionally I draw as well upon philosophers such as Merleau-Ponty, Martin Heidegger and Michel Foucault for a wider perspective upon such phenomena.

The book is meant for therapists and non-therapists alike; it is for anyone interested in this theme of embodiment. What the therapist reader will gain, almost certainly, is a re-orientation of how she or he listens when patients speak about their bodies. Such a change in listening is perfectly possible independently of one's training and methodological allegiances. In addition those therapists who practice "body interventions" will see new ways to think about what they are doing. The non-therapist reader, on the other hand, may be surprised to find how much

more searching inquiry into the nature of embodiment itself, however. Two important exceptions are Gendlin (1962, 1978) and Petzold (1990), both of whom like myself draw upon the phenomenology tradition in philosophy. Some body psychotherapists have also tried to rethink our understanding of the body by borrowing and modifying concepts from the biological sciences (e.g. Boadella 1987, Keleman 1987).

can be discovered about the body through the narrow window of psychotherapy. Though therapy lacks the drama of broader social struggles, and has little of the sweep and refinement of the arts, its very tightness of focus also brings advantages. Things are revealed which otherwise almost surely would escape us.

As an aide to the non-therapist reader I have tried, where it seemed helpful, to translate jargon into more accessible terms. Having taught clinical psychology in universities for over two decades, and having supervised much therapy in diverse mental health institutions, I have often had to face a sobering realization: our professional language would serve us better if it had more transparency. Even seasoned therapists will now and then profit from clarifying what "familiar" concepts are supposed to mean.

I start out in the first chapters of this book by simply giving some basic information. Therapy has come to exist in many forms today. Some forms are what I call the "body-oriented" psychotherapies; these are versions which include active, direct work with the physical body. Since many readers will have little sense how such a therapy might operate, I begin with that. I explain what the setting is like, what the patient might say and do, what the therapist might say and do.

To make this more concrete I next describe a session, one which actually took place and which included a number of body interventions. I first tell what happened and then offer some explanatory commentary. Afterwards I go on, in several following chapters, to show more generally how a therapist can pose questions which help a patient better tune into his or her body. And, how different "levels" of consciousness (images, body sensa-

tions, verbal themes, etc.) can productively be explored. And as well, something of the different types of technique which can be used to intervene physically with the body. And too, how working with the body can give a patient some special modes of access to his or her personal past.

After that we turn down a different road. Tremendous advances have been made during the last two decades by experimental researchers who study infant development. We now know more than once ever seemed possible about how infants move, learn, express feelings, and interact with the adults in their ambient. In a series of chapters I invite the reader to ponder some of the implications of these findings with regard to the body. I also discuss at length a controversy, now mildly famous, between Daniel Stern, a prominent researcher, and the late Margaret Mahler, a psychoanalyst whose theories about early childhood have long been influential in the world of psychotherapy.

This controversy concerns how infants attain a sense of self through bodily interactions. Stern's own research in this area is ingenious. I take issue, however, with some of his conclusions. Using especially a few key concepts from Heidegger, I propose that the findings of Stern and several other researchers have rather different implications than the ones he, Stern, have claimed for them. If this is right, its consequences for the practice of therapy are of the highest importance.

I next return to the issue of how direct work with the body can be useful in a psychotherapy setting. Here I go in more detail into how "somatic memories" can allow a patient to learn about, and learn from, difficult early childhood events in a way which words alone would not make possible. Following this, I take up at length the issues of transference (once again, this is

what the patient, consciously and unconsciously, feels toward the therapist) and countertransference (what the therapist feels towards the patient). I examine how transference can be approached in general in therapy; discuss what else needs to be considered when the body is brought more into the foreground; and then look at the same for countertransference. A continuing theme in these chapters is that an adequate account of the role of the body in therapy must also address the relation of the body to the word.

Body-oriented forms of psychotherapy do have a history, in fact a rather long one. In a late chapter I give an overview of this history, with sketches of some of its central figures. In another chapter I discuss in more detail the ideas of one early figure, Wilhelm Reich. Though not the first body-oriented psychotherapist, Reich created a model which had lasting influence. I find his theory to be more hindrance and mystification than help, however. An affair of "energy flow" and "blocks", it is built around an image of the body as precultural, ahistorical, and thoroughly mechanistic. Even the beautiful biological intricacy of the body becomes erased in this image. For my skeptical evaluation I give a number of reasons.

One more chapter provides a survey of other contemporary body-oriented psychotherapy orientations and styles. There are a lot of them; and many have been responsible for valuable new contributions. I try to indicate in what ways they vary one from another, and what some of their special advantages might be. In a final brief chapter I then return to the theme of embodied mind, pointing out several further implications of the point of view which has been elaborated in these pages.

Chapter 1

WHAT IS BODY PSYCHOTHERAPY?

First, about some terms.

Best I start with the word 'psychotherapy' itself. It is a general, catch-all term, more or less equivalent to the current more popular word 'therapy'. Psychoanalysis, for example, is a subfield of psychotherapy; Gestalt therapy, behavior therapy and family therapy are subfields.¹

I will often speak in these pages of "body-oriented psychotherapy". This is another subfield. Sometimes to be brief I will simply call it "body psychotherapy".

There exist diverse types or methods of body psychotherapy, just as one finds diverse types of family therapy or behavior

¹In the psychoanalytic literature one can find discussions of the question: in what respects is psychoanalysis different from psychotherapy? What this means more exactly is: how should we demarcate the subfield of psychoanalysis from the more general field of psychotherapy?

therapy.² Shared in common by all body psychotherapy forms is this essential trait: the therapist draws upon a repertoire of both verbal and physical interventions. What does that mean?

Suppose you were a fly on the wall of a body psychotherapist's office. Suppose you were a fly who happens already to have a passing knowledge of traditional therapy. Much of what you would see and hear would be nothing new. Patients would talk about their lives; explore their problems; remember parts of their childhood; discuss their feelings, desires, fantasies; and the like. At times however from your fly perch you would witness something quite different. It would take one of two forms.

The therapist might guide the patient in a kind of body exploration or experiment. For this the patient might be sitting; might lie down, a foam pad or mattress being at hand; or might choose to stand.

The flow of communication would then take on some new aspects. From the therapist would come occasional proposals such as: try to find where in your body that sadness seems to be located -- can you explore what is happening in this moment with your breathing -- that stiffening of your chest right now, would it be o.k that you exaggerate it a little -- etc. Also from the patient would come a higher than usual number of reports about bodily states. From the patient as well might come proposals to vary the experiment: I think I'm going to try that little movement with my right shoulder too, etc. Yet you would see at the same time, superimposed upon this new exchange, a continuation of the usual, the traditional one: the patient telling about associ-

²I describe a number of these other approaches in chapter 27.

ations, insights and the like, and the therapist occasionally commenting in turn.

The other kind of event sometimes taking place under your fly perch would be more different still. Occasionally the therapist might work with his or her hands directly on the client's body. Instead of telling him to do so the therapist might actually lift the patient's shoulder. And he might maneuver it in a certain way, pressing here and there, such that several habitually overcontracted muscles now let go a portion of their chronic tightness. Also there might be some talk about this, mostly the patient describing his changing body experience from within. And some traditional therapy dialogue might well take place concurrently: associations, feelings, now and then a response from the therapist, etc.

In sum, picture a traditional verbal exchange taking place most of the time. And then picture an amalgam occurring at other times, an amalgam in which experiments which deepen body experience are joined to the still on-going traditional exchange.

Needless to say, there are many practical questions which such a combination forces one to examine. What happens to transference if a therapist touches a patient? What is the fate of emotions if the patient is changing his or her breathing, muscular organization, and the like? What about defenses and resistance -- could altering a patient's relation to his body circumvent them too quickly? How does a therapist judge when to bring in body techniques and when not? How does she judge which techniques to use, and with whom? And finally, a core question: what about overall integration? How, practically speaking, are the verbal and the body sides of the therapy to be fitted together? Of course standing in the shadow of this last question is a still

larger issue: what kind of theory is the therapist going to hold about embodied mind in the first place?

Before we plunge into these matters a few more orienting comments might be useful, however. As just stated, there exist diverse forms or schools of body psychotherapy. I might add that these approaches tend to differ markedly, their variety being wider than is typical for most psychotherapy subfields. Why should that be? Clearly because there are two massive areas, not just one, where body psychotherapy approaches can differ.

[There is first of all the repertoire of body techniques themselves. We will see how various such techniques can be. Which kinds one school utilizes may be very unlike those favored by another.

[Then there is the entire domain of verbal intervention. What is the general allegiance here? A Gestalt therapy (the method founded by Fritz Perls and his colleagues) orientation? Psychoanalytic? A Transactional Analysis (founded by Eric Berne) slant? Rogersian (the method of Carl Rogers, also called "Client-centered")? Hypnosis? Other? Just think of the possible permutations.

And then on top of that comes what I will continue to insist on as the core question: how do the verbal and the physical interventions come to be fitted together? What is the commitment there? How does the therapist effect the "weave," as I will call it later?

[The characteristics of the particular body psychotherapy method I discuss in this book might be summed up as follows. First, its verbal side is drawn mainly from psychoanalytic object relations theory (for the reader unfamiliar with this name, I

explain it several pages below). That means a verbal tempo which is slow rather than speedy, and an emotional atmosphere more often a quiet simmer than a hot boil. It also means that a systematic exploration of the client's transference frequently occupies the center stage.

Second, the body techniques cover a comparatively wide stylistic range. The majority are what in the metier we call "soft" techniques: non-intrusive, somewhat delicate, an emphasis upon gradual increments of bodily and affective change rather than sudden breakthroughs. Examples will be given. For reasons to be explained later, many of these techniques revolve around the patient's inward contact with her or his breathing.

Third, patients of very different types and diagnoses can be treated with this approach. This includes the farther reaches of serious psychiatric symptomology. That aspect of this method is perhaps one of its more unusual. Many of the therapists using it are doing so in public health settings: psychiatric hospitals, community mental health centers, psychosomatic hospital services, and treatment centers specializing in such problems as addiction, eating disorders, and the traumatic effects of childhood sexual abuse. (In Europe, where I have long been living and teaching.) Naturally, when practiced with such patients, the therapy becomes very different than with more "solid" patients. I will try in this book to convey something of this continuum.

Why the turn towards psychoanalysis? There are so many other possible avenues.

Offhand one might think that the "humanistic therapies" -- Gestalt therapy, Transactional Analysis, Client-centered (Rogersian) Therapy -- would lend themselves more readily to a combining with body techniques. And in fact these methods can be

quite nicely united with a body approach; I know well, since I often teach therapists from those backgrounds. They are methods I appreciate and value.

My own professional odyssey has brought me somewhere slightly different. I started out learning psychoanalysis, in the U.S. and in France. I was also teaching psychoanalytic theory in the university. Fascinated by the rise of the "new therapies", I changed directions. I left psychoanalysis aside; put myself through trainings in diverse humanistic therapy approaches; and fell in love above all with various ways to work therapeutically with the body. But I soon found out that, from my perspective, something was missing: an adequate comprehension of, and attention to, transference and countertransference. This is a big gap, as I think will become apparent in these pages.

Essentially that is what brought me back to -- I won't say psychoanalysis proper, but to a neighborhood right next door. There was really no other choice. In no other current methodology can one find the necessary wisdom about the transference/countertransference dimension of therapy.

Of course to speak of "psychoanalysis" today is not to speak of the same thing which existed in Freud's time. Psychoanalysis has itself now become a rather large and heterogeneous landscape, with its own branchings and subdivisions. The form with which I identify myself (i.e., in the next door sense) is what is now called "object relations theory".

For the reader unfamiliar with that term I had better say right away that it is a less than fortunate bit of vocabulary. An "object" is, ironically, here not a thing but a person; i.e., a subject. Freud originally talked about drives having an "object" in the sense of a target for the drives, a lure. That was

how the word entered the professional lexicon. The mother, for example, is the infant's first "object."

You could say that "object relations" therefore designates relations between persons. The intended implication is that the psyche is inherently relational, that it is a self-in-connection-with-others rather than a kind of enclosed, contained unit. (I will later argue for a similar view of the body.) And in practice object relations therapists put a strong accent on looking at a patient's interpersonal relations. The therapist tries to get a detailed feeling for the patient's internal pictures of others, her "inner objects." And a feeling too for how she concretely acts with the real persons in her world, her "outer objects".

Although early versions of object relations theory were developed by Melanie Klein and Donald Winnicott, it is in its contemporary dress and version that I find it most fruitful; particularly as represented by psychoanalytic therapists such as Otto Kernberg (1975, 1976, 1980), Christopher Bollas (1987, 1988), Lawrence Hedges (1983, 1992), Joyce McDougall (1980, 1985, 1989) and Thomas Ogden (1982, 1989, 1990).

The principal contribution of this otherwise diverse group is its subtle perspective upon the therapeutic relationship. A close attention to the nuances of transference, and a parallel inner tracking of countertransference, become the means to deepen the therapy. One passes from a focus upon the obvious to a discovery of the hidden. Not that the obvious is not also dealt with; it is, and thoroughly. But other currents of belief and feeling are also allowed to see the light of day. This could be helpful, I think, for any therapy form; but for body psychotherapy, as we will see in later chapters, it is invaluable.

There are additional reasons as well for turning to object relations psychoanalysis. One of its great strengths is its usefulness for the treatment of severely disturbed patients. Earlier generations of analysts had little success here. But modern object relations therapists have been able successfully to extend their methods to this difficult domain. As just mentioned, many of the persons I train and supervise are working with clients who suffer from the more serious psychiatric symptoms: borderline conditions, psychosis, addiction, eating disorders, and the like. These therapists, and myself too, would have far fewer resources for dealing with such cases were it not for the advances which have been consolidated by the most recent generation of object relations analysts.

Nor is that all. An area where object relations therapy differs quite sharply from classical Freudian psychoanalysis is how it understands the childhood past. Freud was most interested in the oedipal period, roughly ages three to six. Object relations therapists push their focus of inquiry farther back. They regard the preoedipal period, ages zero to three, as equally deserving of therapeutic investigation. Indeed they see the earliest preverbal interactions between parent and child, from birth (or even before) through the first two years, as strongly formative for every one of us.

I strongly agree. Not that other eras of the past are unimportant; but to be able to explore the preverbal era as well is immensely enriching. I have already mentioned that work with the body has a tremendous power in this regard (why and how, will later be described in detail). What the object relations perspective can add, however, is a more thorough comprehension of the meaning of early preverbal experience. As we will see, to

evoke the early past, through the body, is one thing. To understand the meaning and the implications of what has been evoked, is quite another.

In sum, one finds a lot of natural overlap between object relations theory, on the one hand; and what actually happens when you work with people's bodies, on the other. This is the logic behind putting the two methods at work concurrently.³ The gain is reciprocal, moreover. As I hope will become apparent, a closer look at issues about the body also leads to some possible extensions and modifications of object relations theory itself.

I should perhaps add a brief word about Lacan. Why, I am sometimes asked, this leaning towards object relations psychoanalysis rather than Lacanian psychoanalysis? In France, where I live, this question usually comes from therapists; and outside France, from persons who are not therapists but whose intellectual concerns (literary criticism, feminist theory, etc.) have led them via other paths to an acquaintance with Lacan's writings.

A long answer would be a book in itself.⁴ A short answer is that for a therapist who works with the body, the object relations point of view in some ways provides a more hospitable home. I value Lacanian psychoanalysis; I once studied with Lacan, and as part of my normal professional activities I often supervise

³As far as names go, it seems worth the trouble to keep some boundaries clear. Once physical techniques are playing a role one should no longer call a therapy psychoanalysis, or a kind of variation of psychoanalysis, in my opinion. What has been established as the "frame", i.e. the basic conditions of the therapy, is too different. The approach presented in this book can accurately be considered a psychoanalytically-influenced body-oriented psychotherapy. But it is its own methodological direction.

⁴Though there are significant differences between object relations psychoanalysis and Lacanian psychoanalysis, in my opinion these differences have come to be exaggerated. This is obviously too large a subject to take up here.

Lacanian therapists along with others. But in my opinion object relations psychoanalysis has gone farther than any other methodology in two crucial domains. First, it has the most developed theory of countertransference (again, this means the attitudes and feelings of the therapist towards the patient). Second, it has the most sophisticated ways of aiding a patient to cast light upon her or his so-called "preverbal" history. These are advantages of irreplaceable importance for a body-oriented approach. However in these pages I will occasionally refer to Lacan and draw upon his insights.

Also worth mentioning is that I will be talking mainly about long-term (often two years or more) individual therapy. There do exist some interesting variations of the body-oriented method I teach and practice. These include group therapy; the therapy of children; a version of family therapy; and some brief therapy modes more appropriate to certain institutional settings. Though these other applications certainly merit discussion, limitations of space preclude their being taken up here. In any case they are all derivative versions. For a better understanding of embodied mind we will learn the most from the journeys of individual adult clients whose quest is for a more extensive personal transformation.

Chapter 2

THE SETTING

Here are a few preliminary details before I turn to how work with the body actually takes place.

The office of a body psychotherapist resembles any therapy office anywhere. With one difference. Somewhere, prominently visible or discretely out of sight, there will be a bed or a foam mattress. If a bed, it will look distinctly bed-like rather than couch-like; it will be slightly wider, in other words, than the narrow version of the traditional analytic couch. That is so the patient, should he or she want to, can have some room to move. If a mattress this object might have its own permanent place somewhere directly on the floor. Or, ready to be brought out at the right moment, it might be tucked away in a closet, or left leaning against a wall.

That addition to the usual office furniture mirrors the fact that the client is not necessarily going to spend the whole hour in the same physical place. There may be some shifting about. It all depends upon the particular session. If, as often happens, the whole session remains verbal only, then there is no

changing places. But if patient and therapist decide at some point upon work with the body, then a move is likely. Perhaps the patient will lie down on the mattress or bed. Perhaps he will stand; some work with the body is done in a vertical position. Or it could happen that he remains sitting, as there are physical techniques possible with that position too. Once in a while a patient might even be asked to move from his usual chair (a comfortable one) to a second chair (a simple one, or a stool with no back). The second chair allows certain postures and ways of sensing the body which a cushioned chair (too soft) would make more difficult.

I myself start sessions face to face -- i.e., both of us sit in chairs. If there is work with the body, then the patient perhaps moves.

Some therapists trained in the present method organize this sequence differently, however. They have the patient lie down right at the start. Usually this is a therapist who, before coming to body psychotherapy, was practicing a strict "couch only" version of psychoanalysis. Now a bed has replaced the couch, but otherwise everything is as before. The patient, horizontal, talks; the therapist, sitting, listens and watches and responds. That solution has an elegant advantage: often the transition from verbal to physical work can happen so smoothly one has the illusion of seamless flow.

What the patient wears, when he actually works with his body, is another practical detail. Here there are several factors to consider. One is comfort; some clothing constricts the breathing and hinders movement. Another is the patient's practical need to exit afterwards not too exceedingly rumpled. A third is that for the therapist it can be helpful, though by no means

necessary, to see details of muscle and skin. But the fourth factor is the most important one: that the patient not feel ill at ease.

Given these factors, different patients opt for different solutions. Some merely lie down -- or stand up -- in their street clothes. Some bring a loose-fitting jogging outfit. Some wear a swimming suit or a tight gymnastic suit. My own policy is to go along with whatever the patient's own choice may be.¹ A good body psychotherapist could work with his client in a winter overcoat if necessary.

A related practical matter concerns when and how the patient dons his chosen body-work attire. Should he simply start the session out that way? Stop and change in the middle? Different therapists handle that in different ways. One easy solution is that the patient wear whatever he plans to have on when working with the body under his street clothes. Then, should we decide during the session to work with the body, he puts his street clothing aside. The bother is minimal.

The transference dimensions of this clothing issue are interesting and are not to be neglected.

On the one hand there are the conscious reactions. Almost all patients go through an initial awkwardness the first time or two they suddenly find themselves in a therapy office dressed as if for the gym or the running track. Then, for the great majority, this awkwardness fades as quickly as it appeared. That is probably because there is an intrinsic human logic to working with the body in therapy; a naturalness, a reasonableness, which in no way can be described from the outside but which the patient

¹ Barring nudity, which in my opinion would be highly inappropriate for a psychotherapeutic setting.

himself is rapidly able to sense.

On the other hand there are the unconscious reactions. These transference responses may be far less rational and practical. Normally they pose no threat to the therapy. But like any other reactions to the therapeutic setting they should be explored and clarified. This point I take up elsewhere, in the context of a more wide-ranging discussion of transference².

The time arrangements in a body psychotherapy setting tend to be quite traditional. With the present method sessions are normally scheduled to be fifty minutes in length. One to two sessions per week is the typical frequency, although a format of three or more times per week is also occasionally used.

How long a patient remains in therapy depends upon her goals. And upon the context. A patient in private practice who is seeking a thorough, intensive experience of personal growth might continue for a duration of two to four years. This is typical. A relevant factor of course is whether she has had some good therapy before. If yes, that might somewhat shorten the time needed for what she now wants to accomplish.

For a patient seen in an institutional setting the goals might be much more limited. And the techniques of the present method might be implemented as a part of a wider treatment program.

A hospitalized anorectic patient, a psychotic patient coming daily to a clinic, a patient in a special program for substance abuse, might all be receiving group and family therapy in addition to individual sessions, for example. Several therapists might be involved. Work with the body would then be orchestrated

²Chapter 22.

with other modalities, and the overall treatment (or at least the institutional phase of it) perhaps relatively brief.

In that instance the purpose is help the patient overcome her immediate symptoms, and get on with her life. Naturally a longer therapy is always possible, later on, should she wish to deepen what she gained in the institutional setting. Patients who have had the opportunity to work with the body in such situations do in fact often opt for a later continuation.

Chapter 3

A SESSION: FIRST OVERVIEW

Imagine this. You have had the opportunity to experience, live, a session of body psychotherapy. Maybe you yourself were the client. Or maybe, being yourself part of a supervision or a training group, you observed, from behind a one-way mirror, someone else as client.

In either case you were there, on the spot. You saw what happened. You felt it. Even if you were only watching, it was a little bit as if everything happening in the client was finding an echo in your body too.

Now it is the next day. You are having coffee with a friend. Wanting him to understand your experience you start to run through the whole thing in all its details. Halfway through you take in his puzzled expression. You realize your friend is not comprehending a word....

Rather a problem. With any form of therapy to communicate what really went on, after the fact, is not easy. So many of the nuances -- a shading of a voice, a gesture -- must be left out; and often the nuances count for everything.

With body psychotherapy that difficulty is magnified. Much of what goes on happens outside the realm we normally capture with language.

Film? Videotape? Drawings? Photos? Logically there ought to be some answer here, but none of them work. Too little of the essential crosses over.

My dilemma now is I have to assume many readers of this book will have never seen body psychotherapy. So I ought to describe it some, on a simple level -- the look and feel of it. After that, our discussions of the many interesting issues it raises will probably make more sense. But how to catch the look and feel?

I have opted for the following. I will describe a session here, but in a one-sided form. We will look at the "body half" only: just the body interventions and some of their consequences. Most of the surrounding verbal context I will leave aside.

The result is more than an over-simplification. By omitting the verbal context I have cut away exactly what I consider the most important dimension of the therapy: the overall integration of the verbal and physical work. However this will better let me first convey some of the atmospheric quality of work with the body.

In addition, exceptionally, I will discuss the same session twice. Once in this chapter and once in the next. In this chapter, foregoing any explanations, I will just recount what took place. I will do so in the present tense, again for the sake of trying to get across the feel and tone of such a session. In the chapter which follows I will then add commentary.

Robert, a thirty-two year old lawyer, was referred to me by

a family therapist. He and his wife had been in couple therapy and had had a good experience with this. Robert had decided to continue therapy on an individual basis.

Competent and disciplined in both his work and his preferred sport (swimming), Robert complained he felt himself "a kindergarten beginner" at making deeper emotional connections. In reality I found him not so terribly cut off. It was rather that he instantly became very cautious -- mistrustful, lightly paranoid -- whenever he was moving closer to an affective experience. At the same time a strong reservoir of feeling seemed present in him. He tended to torture himself with an obsessive perfectionism in both work and sport. On the other hand his life was characterized by stable habits, good practical judgement in the world, and a genuine sympathy for other persons.

The therapy lasted close to three years. His motivation was high from the start on. Everything considered I found him easy to work with.

What I report below was our fifteenth session. In other words we were still early in the therapy. It was only the fourth time any direct work with the body had been introduced.

This session seems a good one to examine here for two reasons. First, it illustrates nicely one of the special types of contribution which work with the body can make. Second, it was at the same time a session which, on the level of its body interventions, was quite simple. Sometimes the physical work required is of a more sophisticated nature, and for that reason more difficult to describe in writing. This session was otherwise. Fairly minimal physical interventions proved adequate.

Robert lies there, relaxed and attentive. His body is

muscular and healthy; he is in good shape at thirty-two. He is always possessed of a certain poise, if sometimes to a slightly excessive degree. Even now horizontal on his back he manages to appear in command of himself.

We are ten minutes into the session. Several minutes ago he has said he wished to work with the body today. I agreed, and we have just started in. Rather than (as is more often the case) attempt through the body to deepen some verbal theme already developed in the hour, we are starting out cold. No prior theme, no horizon of meaning already faintly present. We will just see what comes.

I ask him to tune into how he senses his body at the moment. Meanwhile I find my own attention zeroing in upon his chest. That part of him looks well-formed, adult. Yet for the trained eye there is an evident problem. This is a chest which each time he inhales doesn't budge. Not a fraction of an inch. It is only in his belly that his breath manages to hollow out some room for itself. And not so very much even there. Though rhythmic and smooth, free of undue jerkiness or staccato stop-starts, his respiratory flow is overly constricted.

I ask Robert how from inside he experiences his breathing. His answer more or less duplicates what I am observing. That his respiratory possibilities are limited is already a familiar idea; this was one of his discoveries the first time we worked with the body. Today however his description is more exact, and detailed. He is sensing his bodily reality better. (Everyone's habitual breathing patterns suffer from problems of some kind, by the way. I have never seen an exception. More about this later.)

I decide to propose an experiment. A simple one. I suggest he deliberately, actively breathe a while into his chest, such

that he can feel the ribs rise and fall. He agrees to try. I ask him also to notice carefully what goes on inside, emotionally as well as on the level of body sensation. He starts in.

There is no suppleness to the respiratory movement. I can feel his strain. He is able to make his chest participate, but each time he inhales it is as if to push his ribs upward against a heavy weight. Exhaling, his chest drops only half way and stops. After several minutes he reports he finds the experiment tedious. He ceases, rests, waits. Neither of us speaks.

Would he liked to continue with another experiment? I finally ask. He would. May I use my hands to work on his chest? I may. I move to a little stool near the head of the bed and begin.

Since we have already discussed, in another session, what it is like for him to be touched by me, I do not try to initiate another exchange about that right now. I just work, playing close attention to his nonverbal responses. I have already learned that Robert is comfortable being touched, on a superficial level at least, and that we seem able to operate together without problems in this fashion. (From experience I also assume that behind every client's superficial reactions to being touched there lie deeper, more complex transference reactions. With more solid, well-integrated patients like Robert these deeper reactions usually will not come to the foreground until later in the therapy. (This topic is discussed at length elsewhere.¹)

Technically I now employ, as I often do, a means of manipulating overly rigidified muscle groups which I learned from the

¹Chapter 22.

late Moshe Feldenkrais² and which I have modified somewhat for the needs of body psychotherapy. Leaning my weight ever so slightly in, I apply a gentle pressure at certain points against Robert's rib cage. Both hands work at once. Slowly I maneuver tissue and bone through a series of precise positions, allowing respiratory movement to flow around and through. (These pressures, although neither pleasurable nor painful, almost always have an indefinable "interesting" quality for the client. The feeling is as if sections of one's rib cage were testing out new ways to arrange themselves in space.) After about five minutes, seeing that his chest has begun to soften, I stop and go back to my chair.

Robert now comments that he can feeling something happening in his chest, and that he likes the sensation of it. What I can notice from where I am sitting is that a spontaneous movement is continuing. A small movement, barely visible, but obviously it is taking place without being forced. Each time he inhales a ripple like a miniature wave in water expands across his thorax.

Is it all right to pass on to another step? I ask. It is all right. I suggest he now breathe more amply, letting his breath fill both his belly and chest -- but in a lazy manner, without straining. And too that he place his legs such that the soles of his feet "stand" against the mattress, his knees raised in the air. (This position makes full respiration easier and also allows a wider range of spontaneous movement, should movement occur.)

²Feldenkrais (1970) was not a psychotherapist. His was a purely physical form of work. But his hands-on techniques, with some adaptation, fit excellently into a therapy context. These techniques are not the same, by the way, as his more popular "Feldenkrais exercises".

The sound of this active, more ample breathing now fills the room. There is still plenty of stiffness in his chest, layer upon layer of it really. Nevertheless the ribs are moving now with less of a pushing quality. They swing through their cycle more as if they could float.

After some minutes of this, Robert having volunteered nothing, I check in to find out what he is experiencing. Nothing in particular, he replies. The sensation in his chest still feels mildly agreeable, but that is about all he has noticed taking place. His voice at the moment rings as if he were a touch bored.

A minute or two later he announces his neck is starting to tighten. Soon he reports the tightness has disappeared. On my side I say nothing. I have good reason (I will explain way later) to expect we are heading into something else.

A breath in, a breath out. Again and again.

Robert reports a trace of dizziness. I advise him to continue as before, but to add a voice-tone like an extended sigh each time he exhales. This I know will remove the dizziness.

The next development clearly catches him by surprise. Once in a previous session he has experienced it before, but it takes him aback now nevertheless. A trembling starts up. I see it begin in his upper legs, a barely perceptible quivering. He comments on the trembling, adding that he remembers it from the other session. He says too that this time, like before, he doesn't care for it. I ask why not. Because it makes him feel "out of control," he replies.

I remind him it is quite o.k. to stop the trembling anytime he wants. In point of fact he already knows this, since in the previous session his choice was to shut it down almost immediate-

ly. However this time he tells me he wants to go on with the experiment. He is curious, he says; he wishes "to see what this is all about." I reply that in that case he should continue with the same breathing pattern, and that he should allow his body to respond and react in whatever way it seems to want.

During this last exchange I have been watching him closely, and listening with care to the tone of his voice. On my side I too have to make a decision about whether it fits for him to continue. That Robert wishes to go deeper into the body experiment this time is definitely positive. But a separate factor is his level of anxiety. How scared or nervous is he, all positive motivation aside? I have to gauge that on the basis of nonverbal cues (voice tone, body movements, etc.). What I have observed, I decide, seems in order on that score. Had I seen signs of a mounting anxiety, however, I would have requested that we not go any farther, despite his wish to do so. That is because if we continue the experiment, more is going to take place than some quivering of tissue.

So he goes on. More deep breathing.

The trembling dies away for a few minutes. Then it reappears. From his facial expression I can tell Robert has started half to enjoy it. A moment later he says as much. "Like riding a roller coaster," he describes the sensation.

Gradually the trembling spreads. It climbs from his legs through his pelvis, chest, jaw. Robert's expression of half-enjoyment fades. I ask what he is experiencing. He replies, his voice more earnest than usual, that he feels "something is happening." He wants to stick with it, he adds, he wants to see it through.

He is right: "something" is taking on shape and form. But

what?

The first clue comes only several minutes later. Robert's eyes, which have been open the whole while, begin to look sad. An echo of sadness, hardly a trace, creeps too into the sound he is still making with his exhalation.

I wait for him to say something. He doesn't. After a little I comment on what I am seeing and hearing. He answers that "perhaps" there is a little sadness coming up, he is "not sure". I wait, not challenging this. Soon he shifts: yes, "definitely" he is feeling sad. About what? I ask. He hasn't "the slightest idea". Moments later he announces that the sadness is "away" and that he is feeling "relaxed".

Shall I encourage him to try to get back in touch with it? Shall I suggest he tease out associations to it? Possible interventions. But I hold off, waiting in silence. Before long something new emerges. There is a stirring in his shoulders, a small spontaneous forward (i.e., upward towards the ceiling) movement. I call his attention to it. He comments that he feels the movement occurring, but evidently he finds nothing else to say about it.

I suggest that he explore the movement: that he see more exactly what he wants to do, where it wants to go, what else in the body wants to join in. (Ferenczi (1955) once rather neatly called this a free associating on the level of gesture.)

His face looks concentrated, puzzled. For a minute nothing happens. Then the movement occurs a couple of times more, the shoulders inching forwards and back. Then a third time; only now his arms are suddenly swimming into the air too, tentatively, awkwardly. Finally the gesture firms up with the arms extended and the hands and fingers spread open. The act is one of reach-

ing; it could not be more plain. Robert cries.

There exist many ways to cry. I would call this a moderate crying, more a sobbing. Which is fine: it is a step for Robert, and he is giving himself over to it more freely than I would have expected. I ask myself if I should speak now, perhaps offering support, perhaps requesting associations. Instead it feels right just to give him room. He doesn't look scared by the sadness. Upset rather. Mournful.

After a few minutes the crying fades. Robert turns over onto one side, still without a word, and curls up. I tell him to wait as long as he wants before talking about it.

When he does tell me what happened, it is my turn to be surprised. "When my arms were reaching out I saw my father's face," he reports. "His face was hard but his eyes looked lonely and sad. I wished I could do something for him somehow, console him or something." What surprises me is not this image itself but Robert's having brought it so easily into consciousness. I had expected to have to aid him with the next step: using associations to uncover the content of the sadness. No need. The curtain lifted by itself.

This piece of work with the body has lasted about twenty minutes in total. For the rest of the session we speak about Robert's father, and about their relationship when Robert was a boy. I will summarize only. His father has been dead for some years now. For a long time Robert, as a adult, has carried around this conscious image of their former connection: (a) that when he was a boy his father was critical, controlling and slightly sadistic, and (b) that he, Robert, hated him for those qualities. And this, to his mind, was the sum of the matter.

But this sadness which has just surged up hardly fits that

narrow picture. That is as obvious to him as to me. Back then, alongside the story of hatred there must have once been another story: a history of love, and of desire, and of immense disappointment.

Two aspects of this other story hit Robert today especially hard. One is his sense, in the visual image which appeared to him, of his father's hidden inward pain. The second is his, Robert's, earlier desperate but helpless yearning to rescue his father from that pain.

Robert leaves the office looking thoughtful. There going to be a lot to speak about.

Chapter 4

A SESSION: SECOND OVERVIEW

Let's walk again now through the same piece of the same session. This time with more explanation. I will point out several different stages or phases in the sequence of Robert's bodily states. At times I will digress as well, in order to give some more general information about the nature of body psychotherapy.

First, a word about where we were in the therapy. And about the overall problem of when to introduce work with the body.

With the present method one doesn't begin with physical techniques right at the start of a therapy. The early sessions are verbal only. Exactly when first to propose a move to the body represents a major decision.¹

That depends very much upon the nature of the client, diagnostically speaking. And upon the early evolution of the verbal

¹Later (chapter 7) I will make a distinction between what I call "internal" and "external" physical techniques. The work with breathing described in the previous chapter is an example of the use of external techniques. When I speak now about the decision to move to the body, I mean the introduction of this form of technique.

therapeutic dialogue. For example, what form of "working alliance" seems to be developing? And more significantly, what goes on when the therapist poses questions about transference issues? These and some related criteria must be well considered. Only when they are fulfilled does the therapist seriously look at the possibility of adding work with the body.

The reason for that caution, you might suppose, is that work with the body can so easily touch upon affects. But this is not exactly what is at issue.

True, if the physical work is carried out in the same style as during the session with Robert, then indeed emotions may come into play. True also, for many clients too sudden a contact with affect is contraindicated (i.e., better for the time being not to engage in this). However, that in itself is no barrier to working with the body. With a client who is anxious about emotion one can (and should) organize the physical work in an almost totally different manner. The therapist switches to other techniques, ones which have more minute and controllable results (c.f. chapter 7). This will effectively circumvent the chance of the client being overwhelmed by more emotion than she or he is ready to handle.

Instead the reason for waiting longer before introducing physical work has to do with the potential effects upon the transference. Here some impact is always registered; and perhaps a considerable one. Think, after all, of the enormity of the transition: from a therapy where talk alone has dominated to a therapy where the client's body is now in question (and where physical touch might be used too, although that as well depends upon the nature of the client). Consciously this may all be fine for the client. On the surface she/he may strongly welcome it.

But unconsciously her/his reactions may be many-sided, a complex mix of hope and fear, of idealizations and fantasized threats.

Hence there are definite advantages in not introducing the work with the body too hastily. The working alliance can be better consolidated. And a set of rituals -- an atmosphere, a manner, a vocabulary -- concerning the examination of transference can be set into place. (How this is done I take up elsewhere²). That will have a large pay-off, and especially with more disturbed patients, at the moment of the transition to the body. The client will have learned, if in a beginning way, how to uncover the more hidden layers of the transference. So whatever the impact of this momentous change in the therapeutic frame, this impact can now be better gauged, recognized, explored, understood.

Thus, to return to the session with Robert, the fact that by the fourth month of the therapy he was already working with the body says something in itself. With a more problematic patient -- e.g., most psychotic and borderline clients, some psychosomatic clients, and some narcissistically disturbed clients -- I likely would have waited considerably longer. (At times even the first year or more of the therapy consists of talk alone.³) Robert, however, was a quite solid person; neither fragile, nor prone to destructive acting-out. He had also already profited from some helpful previous therapy, and his motivation was high. Thus

²See Downing, *Transference, Countertransference and the Body*, forthcoming.

³Assuming one or two sessions per week. And assuming therapy on an outpatient basis (i.e., the patient is not resident at a psychiatric clinic or hospital).

For a hospitalized client the conditions can be somewhat different. Much depends upon how any work with the body is integrated into a more overall treatment program. This is a subject too large to take up here.

there was every reason to start with physical techniques earlier rather than later. This judgement was confirmed too by his evident ability, whenever we did work physically, subsequently to integrate a good part of what had been accomplished. He could take the experience in; contain it, digest it; and often afterwards elaborate it further.

There are many ways during a session actually to introduce a physical technique. In our session this move was of the most simple form possible. Robert came in that day wanting to work with the body; so we turned our attention, almost at once, to that. This is one way to do it. (More frequently, one postpones the physical work until a little later in the session. First a verbal exchange is pursued, to the point that some theme or topic has taken on a more definite shape. Then work with the body can serve as an affective extension of that theme.)

Note too another aspect of this beginning. It was myself who proposed the first breathing experiment. And then each technical step which followed came too at my suggestion. In other words, the "body work" segment of session unfolded in a highly directive fashion. While it was Robert who made the initial decision to move to physical work, I supplied the overall structure of what we did after that.

This, in my opinion, ought to be a temporary situation. The therapy should not, during the physical work, endlessly continue that way. That would build in too much directiveness. Over time such an imbalance could well create some unwanted effects -- for example, a subtle infantilizing, or a reinforcing of passivity.

Fortunately there exists a good solution to this dilemma. During the earliest phases of working with the body (i.e., like

this session), one just does it in a straight-forward directive manner; there being realistically no other option. But as the therapy proceeds, the client is encouraged to participate more and more in the "structuring" decisions.

This becomes progressively possible as the client gains more familiarity with the range of technical maneuvers. In a later session, for example, it might have been Robert's idea, rather than mine, that we focus upon his chest. He might have walked in with a dream about his chest. Or with feelings for several days of "something going on there". He might even have expressed a preference for using a certain type of technique in order to concentrate upon that physical area. In this fashion, with time, the structuring of the body-work portions of sessions takes on more an atmosphere of "joint work".

Now about the actual techniques. I had Robert experiment with several alternative forms of breathing in his chest. Also I worked with my hands there to loosen certain chronic muscular holding patterns which were constricting his breathing. To what end?

Two things at once are being accomplished. First, a re-organization of the respiratory patterns themselves. This is a long-term goal, fulfilled a tiny bit at a time. It requires many occasions of such work. The eventual result will be that the person "makes a new home" within his breathing, a consequence which I will discuss elsewhere (chapter 7).

The second goal is a more immediate one. It has to do with effects operative right away. To open up the breathing in this fashion will initiate what I call a *body process*. This is a sequence of successive bodily states. It is a progression pass-

ing through recognizable stages, the gradual unfolding of which offers some very interesting therapeutic opportunities. I will explain.

The first phase of a body process I call the *stage of incubation*. In duration it may last anywhere from several seconds to fifteen minutes; occasionally even longer. Four or five minutes is typical.⁴

The most sure way to have the client enter this stage is to help him, on the spot, to alter his breathing. This can be achieved by many means; the available physical techniques number literally in the hundreds. As he chooses from this repertoire the therapist will have several factors in mind. He observes, for example, which aspects of the respiratory cycle are working well, and which appear dysfunctional (c.f. chapter 7). He notices too the location and degree of chronic muscular holding (a therapist can be trained to see this quite accurately), and he judges its influence upon the respiration.

In addition the therapist must take into account what forms of technique he thinks this client can comfortably tolerate, without undue anxiety. For example, should touch be utilized, or not? (Plenty of physical techniques require none. An entire therapy, if warranted, can be carried out with no touching.) And the shifting of the respiratory cycle: how minimal or large should it be? How sizeable a change can this patient likely handle? (More about the technical side of work with respiration will be explained later.)

⁴In actuality there exist several forms of body process. Since my purpose now is to lay the groundwork for discussing some other issues I will describe one type only. It is the type most frequently utilized in a therapy.

You will recall that with Robert I worked upon his chest. I didn't have to begin here; this was only one option among many. Though there are exceptions, usually in itself this bodily starting point itself is not so terribly important. During the course of the therapy one will work with a number of different body areas; some of course more than others, depending on the degree of "defended" quality (c.f. chapter 16). But which area is selected on any one day counts for less than what is done afterwards with the emerging body process.

The usual characteristics of the stage of incubation are as follows. The patient will likely experience a mosaic of *scattered small sensations* together with *scattered small movement impulses*. By 'scattered' I mean discrete, isolated, a mosaic. Now comes a prickling on an elbow. Now a tightness around a knee. Now a twitch of a foot. Minute patches of body awareness, these flicker separately into consciousness and then vanish. The patient will have little feeling that they mean anything, little sense of their coalescing into some wider pattern.

On an affective level the client's mood may hover close to a state of neutrality. He might for example report feeling "mildly relaxed," or "expectant," or "waiting," or "lightly bored." An exception sometimes can be a stream of unaccustomed physical sensations caused by a new shift in a breathing pattern. Normally these are agreeable, e.g. a novel warmth, or a greater ease of respiratory movement. Robert, you will recall, at first felt rather neutral. Then there came a mild passing pleasantness in connection with the temporarily re-organized movement of his ribs. ("Temporarily" because such experiences must be repeated more before lasting change can be seen.) Then relative disinterest again.

This is typical. . . During the stage of incubation the client has the illusion that "nothing is happening". Actually plenty is. The body process, moving along, is warming up. But all of that is occurring underground. The conscious manifestations won't appear until shortly later.

If he wished, the therapist in fact could intervene at this point. He could aid the client to come into contact with whatever is starting, "underground", to take shape, because in reality these scattered sensations and movement impulses are only the tip of a psychological iceberg. Perhaps a client comments, for example, that a fleeting tightening in his upper back "annoys" him. In principle one could investigate this reaction without further ado: he might be encouraged to feel out the nuances of such a "being annoyed", for example. Likely a string of associations leading to relevant personal themes would result.⁵

As a general rule, however, the therapist is better off holding back. The idea is rather to let the body process "cook". At a later point there will be more than enough new material to explore. But then one will be able to do so with more affective depth.

From this perspective, in other words, the stage of incubation is best regarded as only a preparation. It is a warm-up, a lead-in. The important therapeutic work will come after, during later stages, once the body process has built up more power. The therapist waits for this.

* There is one critical exception, however. The stage of incubation often acquires a greater weight in work with more

⁵Similarly a gestalt therapist might have the back "speak" to the tightening, and have the tightening "answer", etc. Another means of elaborating an emerging content.

severely disturbed patients. Or more exactly, with more disturbed patients who just recently in the therapy have begun to deal with the body. Very frequently the therapist then works only with the stage of incubation. It is not a lead-in to anything; it is the whole show.

The reason is that a more disturbed client often has other things to accomplish at this point of the therapy. The emphasis may well be simply upon his learning to experience his body more distinctly -- even if, for the time being, there is not so very much bodily activity for him to sense. The accent in that case is upon clear body perceptions; upon finding appropriate words to label and describe them; upon sharing those reports with the therapist; and upon taking in (i.e., the client taking in), at least a little, that this other, the therapist, grasps what is being said.

This project may sound like nothing at all. But in actuality there are patients who right on this level have a lot of distance to travel. They need to solidify certain of these more elementary capabilities before they work in depth with the body.

* (In their early history the equivalent learning transactions -- feeling a bodily experience and being given the appropriate words for it -- were likely in one way or another distorted. Issues about early development and its relation to a patient's present mode of living his body will be discussed extensively later in this book.)

For Robert however there was no need of a confrontation with these ground-level skills. The bodily and cognitive abilities he lacked were of a slightly higher order. In this session, the stage of incubation served largely as a preparation for what came subsequently.

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The stage of trembling typically is the second to appear. For the patient this stage has more drama to it. Even if, from the point of view of the therapist, this stage like the one before amounts to little more than a creating of the conditions for certain events later to emerge.

Somewhere in his or her body the patient begins to experience what in the language of physiology is called "fibrillation" -- i.e., trembling. There sets in a kind of gentle quivering of muscular and connective tissue.

That started for Robert in his legs. Usually the fibrillation first appears in one of three areas: legs, jaw, or the eyelids (they flutter). After a little, if the patient doesn't tighten to shut it off, it has a tendency to fan out into other parts: pelvis and abdomen, chest, arms, etc.

This trembling is involuntary, but only in a highly limited sense. The client cannot "will" it to start up. It comes up of its own accord. On the other hand the client can easily stop it at any moment he should wish to do so. Flexing a few key muscles normally does the trick. Were the trembling unusually strong he might have to sit up in order to end it. Or (rare) walk about for several minutes.

Why this trembling? What is its value, its role?

Certainly it is a curious phenomenon, fibrillation. There may be aspects we don't completely understand, on both physiological and psychological levels. Nevertheless how it fits into an overall body process is reasonably clear.

Such modes of trembling seem to be simply one way the body "opens up". Some tightness in the tissue softens; more importantly, the trembling works as a stepping-stone to an increased

contact with emotional realities within. The specific physiological trigger is, of course, well known: a shift, in the bloodstream, of the ratio of oxygen to carbon dioxide. Having temporarily altered his breathing pattern, the patient both pulls in more oxygen and expels more carbon dioxide. Eventually that stimulates the trembling. The body process is edging along, and can move further still. (Probably there exist other links in this causal chain yet to be scientifically identified: interlinked central nervous system and autonomic nervous system connections, one would imagine.)

I should perhaps mention, however, that there are some body psychotherapists who, in their theories, make more of this phenomenon of trembling. It represents an outbreak of "energy," is the claim. This should be energy not in an ordinary, but in a special and arcane sense: the release of an esoteric force analogous to (but not the same as) electricity. For my part I find that explanations which base themselves upon this concept fail to bring us very far, however. Later I will offer a detailed critique of this type of model (chapter 20).

On the other hand I think it is also a mistake, as is sometimes done, to dismiss the phenomenon of fibrillation as representing "nothing more" than "hyperventilation". Here we have an often invoked but somewhat confused, and confusing, label.

What is empirically certain is that when a change occurs in the ratio of oxygen and carbon dioxide in the blood, a number of possible physiological phenomena can result: phenomena all of which tend to strike us as either singular or uncomfortable, or both. Dizziness, for example. Or trembling. Or a temporary tightening of the hands and/or feet and/or lips. (It feels like when your foot falls asleep, and disappears right away after-

wards.). Or, once in a very great while, a rapid, high-in-the-chest panic breathing. Unfortunately all of these have come to be called together, collectively, "hyperventilation".⁶

The difficulty is that these responses have nothing in common with each other beyond their shared cause (the oxygen/carbon dioxide ratio shift). Little if anything warrants their landing in the same conceptual basket. Consider only how heterogeneous their practical effects are. (1) Dizziness⁷ and hand/foot tightening⁸ are minor nuisances. (2) In contrast fibrillation, once the singularity of it fades, is a pleasantly-toned experience. More important, fibrillation turns out to be a preparation for, a bridging to, some productive experiences of quite another kind, as we will see. (3) Out-of-control panic breathing is a frightening condition. The client can't stop it (or thinks he can't), and that scares him more, and then his panic keeps the rapidness of the breathing going: a vicious circle. Fortunately its appearance in a therapy setting is extremely rare⁹; and its real danger nothing more than that it might lead to fainting. Nevertheless, should it occur, it should

⁶For a good overview of the physiological research see Fried (1987).

⁷Normally dizziness which occurs during a body process can be easily stopped. Thanks to a physiological quirk (stimulation of the vagus nerve) the patient need merely make a regular voice-tone while exhaling. As did Robert.

⁸Should this occur during a body process there is also no problem. It is harmless, a distraction only. Naturally if it makes the patient uncomfortable he can stop. Usually when it happens at all, it does so only the first two or three times a patient works with the body.

⁹ Perhaps fewer than one in a thousand times -- an estimate.

be stopped at once -- it should be "treated".¹⁰

The obvious way out of this muddle, I am convinced, is to distinguish "true hyperventilation" from the rest. "True" being the out-of-control panic breathing, period. This is a necessary distinction for working with the body, but it ought also to be made in the medical textbooks and in the language used in physiological research. That would have a number of advantages. (One being that it would better clear the way for future research into this phenomenon of fibrillation, and into its intricate functional role in the regulation of affect.)

In any case, practically speaking, for the therapist working with a body process the appearance of the stage of trembling is a positive sign. It indicates the process has now moved another step forward.

For the patient, however, his immediate experience may here feel more problematic. It will engage him; he might or might not enjoy it. This will depend largely upon how many previous occasions, during sessions, he has already crossed this threshold. With time, the client will come to find these states of fibrillation quite agreeable, a kind of massage from within the body tissue itself. In addition the trembling itself will gradually change in nature, its vibrations becoming visibly finer.

The first several times or so, however, the client may well experience this stage with anything from disquiet to strong anxiety. (If his anxiety heightens a lot, then we stop there. A

¹⁰"Treatment" is of course a quick affair. The classic way is to have the patient breathe into a small bag, sending his own carbon dioxide back into his system. Another means is to have the patient walk vigorously, thereby consuming more of the oxygen in his blood. Continued work with breathing in other sessions will soon change the threshold for the hyperventilation response, effectively eliminating it.

general rule throughout all the stages.) Robert, you will recall, this having been only his second encounter in the therapy with the phenomenon, had a typical mixed response. Largely he didn't like it. His complaint that the fibrillation made him feel "out of control" is a statement one hears often. (In reality the client is not out of control, as he could shut down the entire process any moment he wants. Still, such a reaction to so much bodily agitation is natural.) At the same time the trembling aroused in him a strong exploratory interest. This too is common. A client often senses that the fibrillation is like a vehicle in motion, and that it is about to take him somewhere new.

The stage of trembling usually lasts around two to ten minutes before anything else takes place. Occasionally even longer.

The third stage is the *stage of emotion*. One or more emotions swim into the patient's consciousness. They arrive as if from nowhere.

I have watched this sequence of events I don't know how many hundreds of times. I still find it somewhat extraordinary. One can count on it. There are exceptions, but not many.

What surges up may be any emotion, in any shade. Anger, sadness, joy, fear. Gratitude, jealousy, irritation, disgust. You name the feeling: if it exists somewhere on the scale of human affect it can show up during this stage of a body process.

The initial intensity tends to range from light to medium. The client may feel only a trace, a barest stirring on the margins of awareness. Or he may experience something with definite and obvious contours. A sharp, clear, no-nonsense anger, for

example. Or a joy full of affection and confidence.

It may be a single emotion. It may be a mixture of two or more, however incongruous.

What is the most remarkable, however, is not just these affect gusts in themselves. What is remarkable is first, that these emotions are always about something. They have reference. They have an "intentional object", as the phenomenologists like to put it. And second, that this reference or content usually is something significant which happened in the client's childhood past. Either a one-time event or -- more often -- a repetitive series of events, an old pattern.

The reference may or may not be immediately apparent. Sometimes from the first moment the patient is in touch with what the emotion is "about". The relevant thoughts and/or images are present right away. On the other hand, sometimes the patient must pursue his associations in order to disclose these, like unwrapping a package.

What occurred with Robert was a little of each. The reference was hidden at first, as it often is. Only a nameless, imageless sadness floated into his awareness. He hadn't the least inkling what it was about.

Nor at that point did he actively pursue associations. He drifted a little farther with the body process, and then the relevant elaboration came to light through several spontaneous steps. His shoulder started to move, he explored the movement, etc.. And this in turn triggered the key association, the image of his father's face. The only more active inner searching necessary was his exploration of the shoulder movement, done in response to my intervention. On other occasions a more extended search may be required. And at times none at all.

Doubtless you can already see some of the rich implications for psychotherapy. It is in this phase of a body process that the unconscious speaks -- but it speaks *through the body*. An almost inevitably significant unconscious theme presses its way forward. It arrives at the surface of the patient's consciousness, but in a unique form: as a dense, packed-together kernel of affects, thoughts, images, movement impulses, and the like.

In a sense, it is only when this kernel appears that the real therapy begins. Now the therapist must face a series of decisions. How much or little should he or she aid the patient to "unpack", i.e. decipher, the unconscious kernel? Which of its themes should be cognitively explored in depth, and how? What currents of affect are simultaneously present? Should the patient be encouraged to stay in contact with those affects, or even to strengthen them? What about any movement impulses present? Should they be followed out, explored, understood better?

Take for example the moment Robert cried. A therapeutic choice arose at that point. Namely, whether or not to encourage him to deepen his crying; and whether or not to propose other physical techniques (c.f. chapter 7) which would have aided him to do so. This crying, after all, was rather subdued. Much of his body was tensing against it. Through the use of other techniques he probably within some minutes would have reached a more profound level of feeling. Yet as he began talking about what he had just experienced, I decided to go no further with the body. We embarked instead upon a long exchange which was verbal solely. Why?

First, because something important was emerging through the manner of the talking alone. Robert was speaking differently from his habitual fashion. His speaking had more weight, an

increased realness. There was less defensive chatter. He seemed to be feeling out where he was emotionally, and letting his language connect with that.

Second, sadness was an affect with which Robert normally was ill at ease. He felt it seldom, and was a beginner at learning how to deal with it. Often with the present method one encourages a patient to become acquainted with an "unfamiliar" affect slowly, in gradual steps. From that point of view what Robert had already done so far was quite sufficient.

Third, on a cognitive level Robert was also pushing into territory which was extremely new to him. An entire side of his early relationship to his father had never been acknowledged by his adult self. This was a major discrepancy between his habitual picture of the past and how things back then must have really been. To articulate that cognitive insight, to confront it and sift it through, was therefore a higher priority.

* With the present method, in other words, when emotions arise during a body process careful attention is given to them. The main purpose however is not catharsis, or discharge. Instead the primary aims are (1) that the client come to a clear perception of the emotion, including all its bodily manifestations. And (2) that he find some minimal adequate language to describe the emotion. And (3) that he take at least a first step towards finding what the emotion is about (its reference).

After that, the technical possibilities are open. There are a number of alternatives, as we will later see. One among the others is the use of the body to increase the strength and/or the overt expression of the felt emotion. This direction is sometimes taken if the client herself or himself prefers it. Intensified body expression on occasion has its place. But unlike the

aims just described, it is treated as neither a necessary step nor a major goal. Indeed, with clients who have more serious symptomology and a higher level of anxiety than did Robert, often for a long time it is explicitly excluded. (Both their tolerance for contact with emotion may be too low; and their sense of incompetence, when faced with an emerging feeling, too high.)

* Behind that technical orientation stands a broader perspective. Affect is here being approached from the point of view of an evolution of skills. Emotions are seen not as a kind of inner residue to be "emptied out" through discharge, but as a domain where a complex set of life capabilities are at play. These skills have to do with the bodily registration of affect, the sustaining of its flow, the interrogation of its meaning, choices about when and how to communicate it; and much more. All of us to some extent have deficits in these areas. (About which, more later). Therapy offers, as one of its more valuable subgoals, an opportunity to change that.

As for this session with Robert, the work with the body process was concluded with the stage of emotion. This too is typical. Frequently the stage of emotion offers so many different avenues of potential investigation that the physical work ends here. There is much to be done on other fronts.

Sometimes one sees a new development if work with the client's breathing is continued a good many minutes more, however. This fourth stage of a body process, when it occurs, I call the *stage of larger movements*. A series of rather different spontaneous movements will show up. Ample and harmonious, they have their own special quality. For example, the client's legs, still in the knees-up, soles-against-the-mattress position, might

rock alternately right and left in a wide smooth arc. Or a series of stretches might elongate his entire body. Or his spine from head to coccyx might undulate in a graceful wave.

These movements also make a contribution. They appear to be yet another way certain affect-plus-movement bodily orchestrations can be re-learned and re-organized. (The importance of such reorganizing will be made apparent in later chapters.)

To summarize, physical techniques which alter respiratory patterns are used to initiate a body process. A sequence of up to four different phases can be then expected:

1. The stage of incubation
2. The stage of trembling
3. The stage of emotion
4. The stage of larger movements

Occasionally a body process will unfold in some other style or sequence. That presents few problems. So predictable is its usual course, a therapist can comfortably base his interventions upon this probability. When an unexpected turning does occur he need merely shift his response accordingly.

Two final comments. First note that, for the therapist, the true craft lies less in the applying of physical techniques than in the dealing with what they subsequently evoke. The physical techniques, novel as they are when seen for the first time, are relatively easy to learn and straightforward to use. What requires much more acumen and expertise are the therapeutic avenues opening up once the body process has reached the stage of emotion. Particularly demanding of subtle attention from that point

onward is the interplay between body experience and language.

Second, remember that in reviewing the session with Robert I have been describing only a portion of one session, a portion given over entirely to body work. If one were to take this as representative for the therapy as a whole it would give an incomplete picture. In a typical therapy, for example, only around a quarter to a third of the total sessions are likely to include some kind of physical work.¹¹ And, at times, briefer amounts of physical work than what took place here.

Especially left aside in the description given so far is the most central thread of all: the slow-moving, progressive "talk" investigation of the client's transference. Before passing on to that critical topic, however, there is a lot more to consider with respect to the work with the body itself. We need next to look more closely at these decision-points the therapist faces during the unfolding of a body process. How does he/she orient himself? What helps him/her make sense of, and respond to, the many physiological and psychological events which are taking place in so short a space of time?

¹¹In the sense of what I call external techniques (chapter 7).

Chapter 5

CONSCIOUSNESS RECONSIDERED

From the last two chapters one fact must be evident. When a patient explores a body process there can be moments in which a lot goes on simultaneously.

This reality alone has some practical implications. Often during the early stages of the body process the therapist must wait patiently, with relatively little to do. Then, the stage of emotion arriving, he may feel as if he is trying to answer half a dozen ringing phones all at once. The patient perhaps speaks up about a sensation in his or her leg -- switches over instantly later to a fantasy -- then all of a sudden wants to drop that in order to describe a new surge of affect. These jumps of discourse may blur into each other so rapidly they become like a cinema montage.

The therapist must jump right along with them. Not necessarily with interventions (often he will remain silent), but in his sheer comprehension of what he is observing and hearing.

His ability to do this, I have found, will sharply improve if in the back of his mind he carries a reliable map of the

potential dimensions of what the client may experience. He needs an outline, a basic profile, of the patient's consciousness, so to speak. For example, right now, at this point of the session, is the client primarily immersed in thoughts? In emotions? In thoughts and affect both? In neither?

Note these are not questions about specific content (otherwise they would ask *which* thought? *which* emotion? etc.). Nor are they about style and tone, in the sense that a client might be speaking rapidly, or with a childish voice. Instead they are about different dimensions -- different aspects, or modes, or regions, or levels -- of conscious experience. Only, to work with the body we need more categories than just thought and emotion. A map having these two dimensions alone would leave you lost before you had started.

What follows is a map which appears to function quite well for the purpose. It demarcates consciousness into what we might call five separate levels.

But first a note of caution. To begin with, no hierarchy is implied here, no ranking. It would be hard to justify a claim that one particular level is intrinsically most valuable than another. On the contrary, I suspect that systems of psychotherapy dilute their effectiveness to the extent that they idealize any single level at the expense of the others.

In addition, this is only one of many possible ways to look at consciousness. One could "carve up", i.e. categorize, our experience in quite other manners. The choice skirts on the arbitrary. Here is a manner intended to serve a specific function: to help the practicing therapist organize how she or he listens to her/his patient.

I will first briefly just describe the five levels. After-

wards we will see how the therapist puts the map to use.

Bardella Wrago

The verbal-cognitive level. This means thoughts. More exactly, thoughts which are either clothed in words, or just on the verge of unfolding themselves in words. If the patient in her awareness is primarily pursuing thoughts, to the relative exclusion of emotion, body sensation and the like, we say at this moment she is "on" the verbal-cognitive level.

But note: to the relative exclusion of emotion, body sensation, etc. A pure and total awareness of one level alone probably never occurs. So to say the client is "on the verbal-cognitive level" is to say only that the verbal component of her conscious experience at the moment looms large. The other components will still be felt, though more marginally.

These could be thoughts the patient is thinking silently to herself. Or she might be speaking them aloud, with her voice, to a real or fantasized listener. Or she could be listening to someone else (e.g., the therapist) speaking, and attending to this other's meaning. Or, in still another version, were she sitting at home she might be reading the written thought of someone else.

But couldn't a patient be thinking thoughts (or speaking or listening to them) and at the same time be experiencing, say, a related strong emotion? Of course she could. In that case we would say she is on two levels at once. She is experiencing a combination, like a musical chord. Various combinations of two or more of the levels are possible.

The image level. This means, for the most part, visual images. For example a visual fantasy. Or a visual memory. Or a

pictorial reasoning process.¹ Or an attending to the visual perceptions of one's immediate surroundings.

Technically speaking, acoustical images belong to this level too. As do images of smell and taste ("suddenly it comes back to me, that smell in the kitchen when my mother was baking cookies..."). I say "technically speaking" because in practice the images which come to a patient during a session of therapy are mainly visual ones.

Naturally anyone with his eyes open, his physical eyes, sees his surroundings and has visual perceptions. His involvement with those perceptions may well be perfunctory, however. We would say he is dominantly on the visual level only if the visual element of his immediate experience was absorbing most of his attention.² A patient lying on his back might suddenly find himself hyperengaged with looking at a crack in the plaster of the ceiling, for example.

The emotion level. Here we find the conscious experience of affect. Conscious awareness of sadness, joy, anger, fear, pity, jealousy, cranky moodiness, excited anticipation, and so on.

¹Or the pictorial elements in an otherwise verbal reasoning process.

²This map, by the way, has little in common with the analysis of experience made by Neuro-Linguistic Programming (Bandler & Grindler 1975), a therapeutic procedure in the hypnosis tradition. I mention it to avoid confusion. NLP postulate three major "representational systems": the "visual", the "auditory" and the "kinesthetic". In NLP what I have here called the image level would be broken down into two separate categories, the visual and the acoustical.

A second divergence concerns the notion of the "acoustical" itself. In NLP someone who is thinking to himself in words is said to be in an acoustical mode. For myself that loses an important distinction: whether, in an act of verbalizing or of listening, one is focused upon the sense of the words or upon their acoustical qualities. There is a difference.

When we say a patient is on the emotion level, what counts is merely his awareness, his internal discrimination of a state of feeling. It is not necessary there be any outwardly visible manifestations. A client who reports feeling sad is on the emotion level. No matter whether or not he has an unhappy look on his face, or is speaking in a sad tone of voice. (This assumes of course an honest report. And that the patient does not have some unusual, gross deficit in his capacity to label feelings.) Naturally an immobile face and a habitually flat voice might become issues for the therapy. But that is a separate affair.

The sensation level. Here we have conscious awareness of body sensations as such. For example warmth, coldness, pricking, tightness.

It includes sensations both at the surface and deep inside the body. The itch where the mosquito bit me on my arm. The spasm of my belly which wants lunch.

It includes as well sensations of contact with something external. As I lean against the wall I feel its surface press my shoulder.

Notice that the level of emotion and the level of sensation are not the same.³ Many confusions can result if a therapist, in his thinking, runs them together. With any type of therapy that should be avoided; but especially with body psychotherapy. We might profitably linger over this point for a moment.

³Here is another difference from the analysis made by Neuro-Linguistic Programming. In the NLP model emotion and sensation are collapsed together into the "kinesthetic". From my point of view there exist plenty of clients who are so-called "kinesthetic types" (i.e., in the NLP sense) yet who are very much out of contact with their emotions.

It is indeed true -- and later we will see it is a truth full of consequences for doing therapy -- that a person never experiences emotion without some accompanying sensation. Say I begin to feel sad. If I make my awareness more distinct I will quickly discover this sadness has a bodily locus: in my chest perhaps, or in my throat, or around my eyes, or deep in the pit of my abdomen. A distinct pattern of body sensation will be felt together with the emotion. Here sits the sadness in my chest -- together with a certain tightness, or prickling, or an indefinable empty-like sensation.

But the opposite is not true. A person can experience body sensation, and even experience a great deal of it, yet be feeling only slightly more emotion than a fence-post. In fact, to take an important clinical example, there are some patients who show up for body psychotherapy who are, one might say, gifted at just this sort of thing. They encourage or pressure the therapist to move often to physical techniques. And to these they respond with impressive amounts of body sensation, more or less pleasantly toned. "Now the warmth is climbing up my back...now it's going into my face...now into my scalp..." etc. The only problem is, little or no emotion develops out of these experiences. In this case the therapist had better be very clear about the distinction between emotion and sensation. Otherwise he may be so seduced by the "vitality" being manifested that he will fail to see the defensive function which at least in part it is serving.

The motor movement level. Here we find the conscious perception of how one is moving the body in space. Or, too, how one has positioned the body, should it not be moving.

Awareness of both voluntary and involuntary movement is included. I deliberately raise my leg; I feel my limb climb through space. On a visit to the doctor he strikes my patella, below the knee-cap; I feel my foreleg dart through its reflex extension. Both are experiences on the motor movement level.

Also included is the static perception of how my body is arranged in space when it is still. Perhaps I am holding my right arm behind my back, motionless. I can't see it yet I know it is there. I immediately, directly sense its relative position.

Interestingly, the experience of the *spatial location* of a body part is not the same as the experience of *tactile sensations*. (Otherwise the perception of location would be better understood as an aspect of the sensation level of consciousness.) Paul Schilder (1950) and others long ago established this, experiments with brain lesion patients showing definitively how the two experiential modes are independent of each other.

relational?

All five levels -- cognition, image, emotion, sensation, motor movement -- tend to come into play whenever one works therapeutically with the body. The patient will switch, jump, focus on one level, focus on several in tandem; the changes come quickly. The better the therapist understands these distinct divisions of consciousness, the more easily she or he will follow.

That however is not the only use of this map. Suppose a session is occurring in which there is no direct work with the body. This doesn't mean that the sensation and motor movement levels of consciousness are, for the hour, totally ignored; not in body psychotherapy. The therapeutic discourse will still

touch on those levels, if in a more limited way. Partly that happens spontaneously, a patient in body psychotherapy finding it natural to refer at times to his immediate body awareness. But partly the therapeutic discourse takes account of these levels because the therapist intervenes in a special mode. He employs then what I call "experiential interventions", the nature of which I will explain in the next chapter. We will see then how their use depends on the orientation which this map provides.

Nor is that all. The map comes into play too on another plane entirely. This is the therapist's overall assessment of a patient. One needs to supplement one's diagnosis in the usual sense with an on-going evaluation of how the patient functions on the different levels. Where are his (the patient's) skills well developed, and where deficient? What is the overall picture here? This is extremely useful information.

Bion (1962, 1967, 1979), for example, spoke of clients who cannot think well. Perhaps they can be logical, can ruminate, can talk and reason without any evident "thought disorder". But their thinking in the therapy sessions doesn't go anywhere. They are not, as it is common to say today, psychologically-minded. They manage badly with what Bion called "linking": to bring together element A and element B so as to arrive at insights which move the therapy forward. The transformations of their thought, the recastings of themes in what should be progressively more relevant forms, fail to evolve in the manner needed.⁴

⁴Bion's ideas on this subject have much to offer. In my opinion his analysis badly underrates the body, however. What he calls the "alpha function" -- an ego function which organizes and finds significance in sensory and emotional input -- he sees as operating only at the level of thought. A much deeper understanding of the problems of severely disturbed patients becomes possible, I think, when one recognizes (a) that "transformations" must be carried out on all the levels

Patients of this type are functioning extremely poorly on the verbal-cognitive level. Similar dysfunctional conditions can exist for the other levels. Take the level of emotion, for example. There are patients who manifest what is today sometimes called "alexithymia" (Nemiah and Sifneos, 1970). They live as if their emotional life was largely nonexistent. They can poorly discriminate one feeling from another, they have difficulty putting words to feelings (a problem in combining two levels), and so on. The degree of skill deficit is extreme.⁵

When one regards patients with these glaring deprivations it is easy to make an error, however. That is to exaggerate the "health" of everyone else. Every patient I have seen in therapy, bar none, has had holes and deficiencies with respect to his functioning on the levels of consciousness. The difference is only that usually these deficits are more subtle.

Every patient also has an overall profile here not exactly like any other's. That is what makes a careful assessment so necessary. The therapist must evaluate the patient's functioning on each level separately; and in detail. Strengths as well as weaknesses should be taken into account. (This last point is of

of consciousness, not just the cognitive level, and (b) that patients should be so assessed, i.e., with respect to all levels. To put it in Bion's language, the motor, sensation, etc., levels have each their own version of an alpha function.

* ⁵In a rich body of experimental work P. Lang (1978, 1979, 1984, Lang et. al. 1980) has shown with even more precision how clients who are poorly attuned to all three of the "body" levels -- emotion, sensation, and motor movement -- are more handicapped in undertaking a therapeutic exploration. Phobic subjects more skilled at noticing emotion and sensation and motor movement responses, he demonstrated, can also more easily access their phobia-based fear when hearing a verbal description of the phobia scenario (e.g., "you see a green snake on a rock...."). In addition Lang has demonstrated that clients having strong deficits in this area will show a marked improvement in their results after having received a structured training in body awareness sensing.

particular importance in work with psychotic and the most severely disturbed borderline patients. There will always be some minimal strengths. Those must be carefully noted by the therapist as they may offer her her best means of entering the patient's life-world through "experiential interventions". See the chapter to follow.)

This evaluation should include too the client's ability to make transitions from level to level, and also his ability to combine them when appropriate. In other words the therapist must ask himself three types of question. (Even if to a degree these questions overlap.)

(1) How effectively can the patient sustain a motif on one level at a time? Can she keep one level dominant and maintain a focus there? Can she stay with what wishes to emerge, and let it do so? Can she maintain his receptivity?

Take for example the emotion level. When a feeling like sadness or anger comes up, can the patient sustain this feeling in her consciousness? Can she allow it to build up, develop, modulate, without breaking it off? If circumstances warrant can she let it fill out with the depth it seeks? These too are "transformations," but ones more akin to those of music than of logical thought.⁶

What about with analogous processes on the other levels? Can the client give herself over, in a sustained way, to a flow of images? To an emerging pattern of sensation? To a movement? To a current of verbal thought? With which of the levels does she appear more capable, and which less so? How much do these abilities fluctuate? Under what conditions?

⁶In other words here again is a kind of parallel alpha function Bion overlooked.

(2) How effectively can the patient make transitions from one level to another? Can he, when appropriate, pursue on a new level a motif first encountered on another level? Can he pass from an image to its corresponding cognitive reflections, from a stream of thinking to something which reflects it in a movement impulse, from a movement or gesture to a relevant emotion, etc? These also are "transformations", and of yet another kind. Many such permutations are possible.

(3) How effectively can the patient combine two or more levels? Can she, when appropriate, allow a motif to develop on two or more levels simultaneously? For example she might stay in touch with an image and at the same time explore movements which its presence seems to elicit. Or pursue a train of thought while allowing its emotional impact to reverberate simultaneously. Here again, many combinations are possible.

A basic goal of therapy is that these skills improve. Potentially a patient may develop better functioning on all the levels of consciousness. Not only will he build up more of the needed abilities; he will build up too his sense of agency concerning them. He will learn to perceive the tiny choice-points, the minute forkings in the road, within his experience. "I'm starting now to shut off this sadness; do I really want that?" "This image of my grandmother's face: shall I see what gestures it wants to pull from my body?" Not that anyone thinks it out this way in words. But the flickering perception of choice is there.

In an important sense this is part of how a person changes, when things go well, in classic psychoanalysis. Ostensibly in analysis the client should let herself free associate. She

should let anything which wishes float into his mind, and at once report it. But, as has been remarked, the whole point is that in the beginning one can't do that; or rather one can't do it very productively. Few associations come, or an excess of trivial ones, etc. Only gradually in the long course of the analysis will a patient construct the skills she requires in order effectively to use free association.

That particular learning process which a patient in psychoanalysis undergoes we can quite nicely describe with respect to the levels of consciousness. Generally speaking, free associations are tracked on the cognitive and the image levels. The patient goes from word to word, from image to image, from word to image, etc. The major goal naturally is what in the literature is called "affective insight". That is what gives work with associations its therapeutic power. "Affective insight" is of course a bringing together of the cognitive and image levels with the emotion level. This is, more than any other, the practical working capability which the client usefully develops. This is the instrument, so to speak, which he will apply with progressive effectiveness to an understanding of his life, his childhood, his relation to the therapist, and so on.

As you can see, the parallel with body psychotherapy is evident. What is different, techniques aside, is that in body psychotherapy the sensation and the motor movements levels are brought in as well, and extensively. But otherwise the overall project is highly similar. New skills in pursuing a process on any one level are formed. New skills also in making transitions; and others too for bringing the levels together. As is the case in psychoanalysis a therapeutic instrument is slowly forged. The patient will turn these abilities, once honed, to a progressively

deepening confrontation with his life, his past, and the vicissitudes of the transference relationship.

Having said this, however, I must correct a possible misleading impression. I have spoken as if psychoanalysis in general tends to leave aside the sensation and movement levels of consciousness. But there exist today diverse styles and varieties of psychoanalysis. Even within the confines of a single school one can come across surprising large practical differences; I know that well from having supervised a good many analysts.

One way analysts vary, and enormously so, is in their sensitivity to the body. Some in fact are quite ingenious at reaching the sensation and movement levels of consciousness with their patients.⁷ I don't mean to imply they work actively with the body (as, e.g., Ferenczi (1955) did for a period⁸). I mean they successfully create a climate where the patient finds it natural to tune into her or his body, and natural as well to talk about what she/he discovers there. That can much enrich the work with associations, with transference, and the like.

This is a side of psychoanalysis which remains full of undeveloped potential, in my opinion. After all, it was Freud himself who proposed that the body should "join in the conversation" -- i.e., that reported body experience can have many subtle

⁷This also is a craft which very much can be learned.

For relevant discussions of how to include the body in a psychoanalytic discourse see Boyer (1983), MacDougal (1985, 1989), Anzieu (1989, 1990) and Ogden (1989, 1990). Boyer's treatment approach to psychotic and highly disturbed borderline patients is a particularly good example of therapeutic acknowledgement of the body. Speziale-Bagliacca's (1991a) exemplary attention to the bodily levels of countertransference should also be mentioned.

⁸C.f. chapter 25.

connections with the rest of the therapeutic exchange.⁹ Psychoanalysis is not the same thing as body psychotherapy. Their effects can not be exactly alike, nor should be. But within a strict analytic frame there remains plenty of room for body experience. Once an analyst has grasped what needs to be comprehended in this domain, such a discourse can sometimes touch the most profound bodily layers.

⁹See Breuer & Freud 1893, p. 296, and Freud 1918, p. 76. Much of Freud's thinking about the body was in fact more complex than commentators have tended to recognize (c.f. chapter 25). This is a large and interesting subject in itself.

Chapter 6

EXPERIENTIAL INTERVENTIONS

I want now to give more of an overview of the major techniques of the present method. That is, of the techniques which have to do specifically with the body.

In part this means physical techniques, naturally. But there is another part too: special verbal interventions which are designed to explore body experience. Some body psychotherapy approaches, for various reasons, do not bother with such interventions. However in the present method they play a central role. I will therefore describe this mode of intervening first, and then in a chapter to follow the physical techniques themselves.

One of the keys for a therapist to get better at what he or she does is to become aware of the precise effects of his or her interventions.

"What comes to mind?" Four classic words, in the psychoanalytic tradition. It is a good intervention. I use it myself happily. But consider a noteworthy limitation.

"What comes to mind?" -- implicitly the patient is being told to leave aside her body experience. She is being asked to go inside, to be receptive, to find what "comes". But the field of her focus has been narrowed down at the same time. She should limit her attention, the intervention implies, to the cognitive and image levels of consciousness (c.f. the previous chapter). Words, thoughts and pictures have been asked for. Body experience has been ruled out.

Is that bad? In one sense, not in the least. Much excellent therapy can be done with a focus upon the cognitive and image levels. But also what is lost should not be denied; what is lost, that is, if this intervention and its close cousins are used almost exclusively.¹ Over the months this sends a strong message to the client about what is expected in the therapeutic exchange. It tells him where to put up fences in his discourse.

Are there other options? Decidedly. In therapy there exist many types of intervention: confrontations, requests for clarification, interpretations, and the like. One important type is what I will call *experiential interventions*.² If we examine how they function, we will see how a wider spectrum of technical choices can be made available.

Experiential interventions are ones which suggest to the

¹Another familiar example: "what are your thoughts about this?" Also a fine intervention. I couldn't picture doing therapy without it. But note how the zone of receptivity has now been reduced even further. A focus upon the cognitive level alone has been requested.

²Langs (1973) has the most thorough account, in the psychoanalytic literature, of different forms of intervention. But his insightful discussion has a striking lacuna where it comes to what I am calling the experiential. Again the body has been excluded and marginalized.

patient: go now within yourself and notice what goes on. Find what is there now, find what comes the next moment. Such an intervention can be extremely general, implying an open look at the full flow of experience. Or it can propose a tighter scanning of one or two levels of consciousness alone.

From this point of view, to ask a patient to explore associations is a subtype of experiential intervention. The suggestion in that case is that he should scan the cognitive and image levels, reporting what he finds emerging there. An equivalent intervention on the sensation level might be: "explore what sensations you experience now in your body". In both instances the request is for a tight focus on a single level, or on two levels at most.

But a tighter focus is only one option. It is also possible for experiential interventions to be more open, more general.

That is their other pole. "Notice what comes to you now." "What is happening inside you now?" "What are you in touch with?"

"Where are you now?" Here are interventions so global in their implied scope that a patient might well reply on any level. He might equally report a movement impulse, or share a thought, etc.

Other interventions are fairly open, but less so than these most general ones. "What are you experiencing right now?" Another wide intervention. But in practice a patient will normally respond by talking about either images or body phenomena -- affects, sensations, movement impulses. Almost certainly he will exclude thoughts and word-associations. (This practical fact about how patients answer mirrors an interesting semantic reality: that the concept itself of experience has an ambiguity at the heart of it. One way to think of experience is as the flow of everything we are aware of -- including, obviously, the on-going

will elicit a scanning for movement impulses).

Notice too a distinction of another order. Some experiential interventions imply: go inside yourself and see what is already there, already formed, as a piece of experience happening right now. (This might be in respect to any of the levels.) Other experiential interventions imply: go inside yourself, be receptive, and let the next dewdrop or dewdrops of experience take their shape. "What are you feeling?" suggests a finding of what is already there, for example. The implied time-unit is the last several seconds or so ending with the razor-edge of the now. Whereas "see what associations come to this" suggests an attending to the next dewdrops about to form. The implied time-unit starts with the razor-edge of the now and extends several seconds or more forward.

Both modes are useful. Both aid the patient in learning how better to make contact with himself. The second way, however, the waiting to sense what forms itself next, is generally for the patient more difficult. A more zen-like, more meditative set of skills must be developed in the therapy in order for him helpfully to utilize the second mode.

I emphasize this distinction because there exists a special variation of the second, the "waiting to sense" mode. It has to do with affect. It is a body psychotherapy variation. It comes into play during the stage of emotion in a body process.

As already mentioned, a patient can sometimes face a certain problem while exploring a body process. It can easily happen that an emotion emerges, but its reference, its "aboutness", is unclear. The patient senses a trace of anger but has no inkling of its cognitive content, for example. What can be done at this

point?

A good option is that the therapist just stay quiet. Especially with a patient who is already familiar with "waiting to sense". The patient can quite well struggle on his own. If the search for the referent fails, little matter. There will probably be other opportunities later in the body process. And other opportunities as well the next time physical techniques are used in a session.

But imagine a patient who has only just begun in the therapy to explore these body process phenomena. Imagine a patient likely to flounder and get nowhere, a patient devoid, up to now, of any mastery of the "waiting to sense" mode. In that case a special form of experiential intervention may be warranted.

Suppose that this client feels the same trace of anger. And its "aboutness" totally eludes him. The therapist might then propose something like, "why don't you stay with this feeling, and see if you can let any images come to you." Oddly, this intervention, by focusing on one level alone instead of all of them in general, makes things easier. Usually. The patient who a moment before could find no associations may now see an image of, say, his family at the dinner table when he was eight; and the exploration is underway.

A similar possible move: "perhaps you could stay in touch with this anger, and find out if your body wants to make a movement or a gesture." Here the focus is on the motor movement level. In this example the client might make a fist. Or perhaps, not actually making it, he might report the impulse to do so. But what is interesting here is that once he has let the fist-making movement (or fist-making impulse) crystalize, then a continued series of new associations is likely to be liberated: a

chain of thoughts and/or images which now clarify the anger's "aboutness".

Normally these particular variations become obsolete a bit later in the therapy. They will have accomplished their task. Thanks to their aid the patient will be better equipped for those special moments in a body process when he must confront the opaqueness of his own affect. More in possession now of the necessary resources, he will have become accustomed to ferreting out an affect's meaning-connections on his own.

Needless to say, experiential interventions lend themselves well to body psychotherapy. That does not mean however that all forms of body psychotherapy use them. In fact, whether they are used at all, and for what purposes, is one of the more defining characteristics of a body psychotherapy approach.

For the present method they have considerable importance. There are two reasons for this.

First, experiential interventions provide such a good means to insure that some dialogue about the body will continue even during sessions where no actual physical techniques are used. Remember, with the present method, for most patients, a majority of the total sessions are verbal only; and have no explicit physical work. So this is a more pressing issue than it might be for body psychotherapy approaches where the body is worked with all or almost all of the time.⁴

Second, with this method a lot of attention of a special

⁴Lowen (1958, 1967) for example uses extremely few experiential interventions. But they are also less necessary to his approach, as direct work with the body occupies close to all of the therapy hours. (C.f. the discussion of different schools of body psychotherapy in chapter 27.)

form is given to what I have called the preparation period. This is the phase of the therapy which precedes any use of physical techniques. There are several different essential tasks to accomplish in this period: one being (some others I will discuss later) that the client learn how to bring the body into the therapeutic discourse.

For that, experiential interventions are invaluable. They help with all clients, but with severely disturbed clients they are absolutely critical. (Recall too that for more disturbed clients the preparation period tends to be considerably longer.) This mode of intervening offers them a way to attend to the body which is minimally threatening. Also it allows the therapist to measure how well the client can accept an exchange about body experience.⁵ Best of all, it greatly increases the patient's motivation to deal with the body. Well-chosen, to-the-point experiential interventions, even if sparingly used, make it evident to her that there are profound connections between her psychological difficulties and how she bodily relates to the world. Experiential interventions allow her to verify this for himself.

⁵With a few psychotic and borderline clients even a limited exchange about immediate body experience is too much at first. Their tolerance for such a dialogue must be developed gradually and delicately.

Some of them, for example, are literally afraid to sense their bodies. Even the least autonomic stirrings will cause them concern. An increasing heart rate or a pick-up in breathing they quickly construe as dangerous -- e.g., as a threat of a return of psychotic symptoms, or of a heart attack, etc.

With others the difficulty is on a transference level. They too easily interpret the therapist's questions about body sensation as a form of invasion. Still others combine both a sensation-phobia and a transference reaction: they fear that the therapist, by evoking (their own) autonomic arousal, is intentionally or unintentionally pushing them towards a perilous brush with danger.

Of course many experiential interventions must be tailored for a body psychotherapy context. Often they must bring attention not just to emotion, but to the finer specifics of sensory-motor awareness. "Notice what sensations are developing in your body", for example. Or, "how are you experiencing your breathing right now?". But also there are variations which are rather more complicated.

An experiential intervention may be coupled with an observation about the body, for example. "I notice as you talked about your father your breathing changed. How do you experience that?" Or again: "What do you feel going on with your right hand?" (the therapist having noticed the patient has begun squeezing and tensing his hand). In principle the observations leading to such interventions might be about posture; or about movement and gestures; or about muscular contractions (e.g., the patient is tightening the muscles of her brow); or about breathing; or even about autonomic changes (e.g., changes in skin color).

Such interventions, focused tightly upon corporal particulars, have an additional advantage as well. During the early months they introduce the patient to the notion of body defenses -- a notion later to play a large role in the therapy (c.f. chapter 16). She confronts from the inside how, e.g., rigidifying her neck, or letting her arms at certain moments go slack, have been serving lifelong defensive purposes. There is no stronger motivating insight. On the day a client really "gets" how pervasively he is using the body to structure his interpersonal field, his hunger for direct physical work will take a quantum jump. A hundred speeches by the therapist (inappropriate anyway) could not be as effective.

Thus experiential interventions, while in principle useful for most therapy forms, have some obvious special affinities with a body psychotherapy methodology. Their contribution in that context can reach especially far. They expand the content of the therapeutic dialogue. They expand its affective depth too, bringing more awareness of the body into its margins. And they teach by means of direct discovery about body defenses. All of this helps to create much more osmosis between the direct "body work" portions of sessions and the rest of the therapy. A kind of progressive interweaving takes place. The word becomes more grounded in the body.

This does not imply, however, that experiential interventions must be employed in great quantity. With the present method their role is essential; still they are used sparingly, judiciously. The therapist adds them to the therapeutic dialogue here and there, seeking the ripest moments for their effect. Often in a single hour there might occur one or two, no more. But then in another hour a half a dozen might be used; and yet another time considerably more. (I am speaking of course about sessions with no direct physical work. Naturally, whenever there is physical work with a body process, then experiential interventions too become more numerous.) It is a rhythm which well stimulates the desired interweaving, the osmosis, of body experience and language.

What then stands against a more abundant employment? Two things.

First, there is the matter of who structures the patient's discourse. When a therapist comes in often with experiential interventions; when there is so to speak a steady rhythm of them; then the patient ends up in the role of the one who responds to

questions. The patient talks but the therapist punctuates, you might say. In a subtle and, to the patient almost concealed manner, the therapist tends thereby to maintain a pervasive control over the flow of inner exploration. For the wider goals of the therapy this is a loss. Better that, if it has to be, a patient some of the time flounder. Better that he or she fall into silences, talk flatly for stretches, and endure and inflict some occasional confusion. A judicious, selective use of experiential interventions will eventually change this. As will, even moreso, some of the physical techniques to be described in the next chapter.

Secondly, one faces the practical question of available time. A fifty-minute hour is short. The total number of hours, even over two years or more, is not massive. And within this available time there is a lot to do. Above all, with the present method, there is the on-going investigation of the here-and-now transference relationship. And that often enough is a slow-moving affair. It can't and shouldn't be hurried. If a lot of the hour were regularly given over to a high frequency of experiential interventions, then the therapy would end up having little room for a more subtle probing of transference.

Another way to put this last point is to recognize there exist a number of different basic types of intervention. Experiential interventions represent only one type. There are other types which also deserve plenty of space on the therapeutic canvas. In particular, as I have elsewhere discussed in detail⁶, *the interventions which make transference investigation come alive are highly different from experiential ones.* So from that

⁶Chapter 19.

point of view an overuse of experiential interventions would cost too high a price.⁷ In addition, of course, there is the patient's outside life to be discussed. As well as, once the therapy has picked up a certain momentum, her childhood past.

Nevertheless, a selective employment of experiential interventions is a central part of the technical workings of the present method. The moments for their use are chosen carefully; they carry considerable weight. They are what allow the physical techniques described in the next chapter to attain a maximum continuity with the remainder of the therapeutic enterprise.

⁷Couldn't experiential interventions also be used to help explore the transference? Certainly. The client reports feeling distant from the therapist, for example; the therapist might then, through an experiential intervention or two, help him to sense more precisely how he, the client, is organizing his body in the mode of "feeling distant". Most transference exploration, however, must be carried out in an altogether other manner (c.f. chapter 19).)

Chapter 7

MOVING TO THE BODY

In the last chapter we saw how a therapy can include the body even if, physically, one does not "work" with the body. The best access is through certain experiential interventions, which are verbal only. These help the patient build up a greater awareness of sensation, movement impulses, and emotion. Body defenses too can be identified and explored, in a beginning way.

For this one does not have to be a body psychotherapist; any therapist, whatever her or his basic method, can develop the necessary skills. It is a question of learning how to read the cues, and how to understand some key body phenomena. The patient's increased contact with his body will then become an additional resource in the therapy. Gradually it will enrich his verbal discourse, bring him more in contact with feeling, and the like.

Quite another matter is for the therapist to move to active, direct physical work with the body. To introduce physical techniques is irrevocably to pass over a certain line. The "frame"

(the defining conditions of the therapeutic setting) becomes other. Then one is actually doing body psychotherapy. Or doing something at least falling in an intermediate zone between body psychotherapy and one's original method. This has many consequences, and especially for the patient's transference. One should never underestimate the massiveness of such a frame change. Later I shall discuss at length what it implies for transference, countertransference, work with regressive states, and the like.

In this chapter however I want to stay with the physical techniques themselves. I will try simply to give an impression of the different forms they take; leaving aside, for now, all the wider implications of what it means to bring them into a therapy.

I will leave aside too their wider purposes. Let me again summarize, however, what these are. One can cite three distinct reasons for including work with the body in a therapy. First, it more easily reaches both affects and childhood memories. It opens a door to the unconscious, you could say. Second, it provides an access to the patient's preverbal past. Nothing else in therapy does this so effectively and so fully. Third, over time there takes place a re-organization of many body schemas and patterns, as well as a re-organization of the patient's relationship to her body. This too has a number of lasting psychological consequences. How the preverbal past is reached, and how schemas and patterns are changed, will all be taken up later. For the moment we need simply to get a clearer picture of what the physical techniques are like, and how they operate in practice.

Where does a body psychotherapist get his or her techniques?

This depends. Anyone practicing today is in a fortunate position. There currently exist literally hundreds of physical techniques. Perhaps more important, there also exist fundamentally different stylistic ways to approach physical work. The spectrum of possible styles is wide, and getting wider by the year.

The situation was not always so. I remember well a quarter of a century ago when I went through my first body psychotherapy trainings. At that time the body psychotherapy world had a more narrow homogeneity. There existed different schools and theories, but the actual spectrum of techniques was small. A kind of inherited repertoire was being handed on from one teacher to another. Most of these techniques came originally from Wilhelm Reich (1949) and his work in the 1930's and 1940's. (The body psychotherapy tradition goes back still earlier (cf. chapter 19), but Reich was the first to transmit techniques on a systematic basis.) Others came from Alexander Lowen (1958), who in the 1950's had developed a methodology which had become equally influential (cf. chapter 21).¹

Once I began using this Reich and Lowen methodological repertoire with patients, I came to feel it had some serious limitations. And I discovered that a number of other body psychotherapists of my generation were arriving at a similar conclusion.² An inherent difficulty seemed to be that many of these

¹Lowen of course has since continued to develop his approach. As have a number of his colleagues (c.f. chapter 27). Nevertheless the core of his methodology has consistently remained quite close to his technical innovations of the 50's.

²There were exceptions too among those who were teaching in the seventies. Among the teachers I had the good luck to study with were Magda Proskauer (1968) and Stanley Keleman (1979), both extremely skeptical about this emphasis upon

techniques were somewhat aggressive. Designed for a quick mobilization of intense affect expression, they "worked", but in a sense all too well. One was taught to do the physical work in a manner such that the patient could achieve a state of "release" or "catharsis". And the more rapidly she or he moved into that state, the better.³

This ideology of catharsis in my opinion suffered from a number of difficulties, but two especially appeared daunting. The first was that many highly disturbed patients (e.g., what today we call borderline clients) simply could not make headway in that way. The feelings elicited were too overwhelming. The second, if more subtle, was also discouraging. A certain number of more solid clients, entirely comfortable with strong emotions, seemed to get "hooked" upon cathartic outbursts. As a consequence something overly repetitive and slightly artificial began during the middle phases of the therapy to creep into their affective explorations. It was as if a certain ritual was supposed to take place, and they were going to make sure it happened in some form, no matter what.

My own solutions to these issues evolved over the years. Essentially I tried, while staying faithful to the overall project of working with the body, to develop both alternative techniques and alternative ways to implement them. At times I con-

catharsis which in those days dominated the body psychotherapy mainstream. The solutions which over the years I have come to are different ones from theirs. But the contact with their work was invaluable. One discovered there could exist alternatives to the cathartic model.

³One sometimes heard back then, and sometimes hears even today, that the techniques from Lowen are more cathartic than the techniques from Reich. Strictly speaking this is true. But the difference is one of degree and is on the whole slight. In the seventies both approaches were being used for a fast mobilization of strong emotional expression.

tinued to use (and at times still do) the techniques I had originally learned. But for the major part of day-to-day therapeutic work I found I needed other tools.

The prospect of finding them, for myself and for others sharing the same point of view, could well have appeared next to insurmountable. That it did not, has to do with a historical reality. Ours is the century of a new practical comprehension of the body. This is a largely unsung story; few commentators have caught the full sweep of it.

What I am talking about is the rise of "straight body work" -- i.e., physical work designed to produce physical changes, in settings quite apart from psychotherapy⁴. Since World War II there has emerged an extraordinary wave of new practices. New forms of "hands-on" work, new approaches to breathing, new styles of movement exploration -- the sheer inventiveness is staggering. To refer to the methods of Feldenkrais (1970), F. Alexander (1938), G. Alexander (1986), Rolf (1977), Middendorf (1987), Selver (Selver & Brooks 1980, Brooks 1974), and Trager (1987) is to mention only a few of the better known. Some of these approaches have roots in post-World-War-I Germany.⁵ Some even have been influenced by disciplines (e.g., yoga massage techniques, shiatsu) centuries old. The great burst of creativity, however,

⁴When I speak of "straight body work" and, below, of the "pure body disciplines" I don't mean to imply that nothing mental or psychic is involved. Certain of these disciplines, e.g. the work of Feldendrais, rely extensively upon mental acts of sensing the body. Additionally, all these methods have some psychic effects.

⁵Middendorf and Selver, for example, as young women in Weimar Germany were students of Elsa Gindler, a renowned Berlin teacher of what today we would call sensory awareness. I discuss these historical currents more thoroughly in chapter 25.

has taken place largely during recent decades.⁶

This is a piece of luck for body psychotherapists. One is not forced to re-invent the wheel. A therapist can browse, borrow, experiment. The more she learns of these neighboring approaches, the more tools she can find which may prove useful on her home ground.

At the same time it would be unrealistic to expect one could transpose techniques from the pure body disciplines without introducing changes. Modifications are usually necessary, sometimes extensive ones. Body psychotherapy is so different an undertaking. Its setting is other: e.g., one must take transference reactions to work with the body into account. Its priorities are other: e.g., in body psychotherapy the verbal exchange is just as important (or moreso, depending upon the particular method) as the physical work. And its goals are other: e.g., attention to affects must in one manner or another find a central place. For myself this has meant a mixture of modifying and refining, on the one hand; and of developing entirely new techniques, on the other. The same has been true for a number of other body psychotherapists. Especially during the last decade there has occurred much expansion and refinement of technical styles (c.f. chapter 21).

I will now go over several basic types of physical technique.⁷ I will not try to describe them in close detail, my purpose being to give an overview rather than to explain how one

⁶For excellent overviews see D. Johnson (1994) and Murphy (1992). Johnson's book includes a long and moving account of what it can be like on a personal level to experience these forms of work.

⁷For a useful discussion of techniques which categorizes them in a quite different manner see E. Smith (1985).

would actually execute a specific maneuver. They are all types which I advocate and which I teach to therapists in training.

Some utilize physical touch; some do not. Some address themselves to muscular tensions; some to breathing patterns; some to movement and gesture; and some to affects. As will be evident, their purposes, their manner, and the conditions for their use vary greatly.

Repatterning techniques.

Repatterning techniques are a "handling" of the physical body. With quite precise maneuvers the therapist lifts and then moves, bends, stretches or twists some part (e.g., a shoulder) of the client's body. That part is maneuvered, or held and suspended, such that a shift can occur in the tonus level of certain targeted muscles. Done correctly, this realigns overcontracted muscle groups. Tissue which was in a state of chronic constriction is loosened and eased.

For example, shoulders which chronic tension has locked into a place too high, or too rounded forwards, or pulled too far backwards, can step by step be allowed to gain a more optimal position. And in principle any muscle group anywhere can be worked on in the same manner. The transformative steps are minute, of course. And if their effect is to be lasting they have to be repeated somewhat in subsequent sessions. Necessary also at times is that complementary body areas receive some corresponding work. An easing of constricted neck muscles which pull the head too far forward may have to be balanced by a slight shift in the lower back, for example.

In general, the entire body head to toe has the potential for this type of re-structuring. You cannot throw away your old body and be given a new one. But perceptible, lasting change can occur. More extreme problems of alignment (how one part is held in relation to another part, e.g. shoulders too much rounded over the chest) can be reduced. The range of movement in the joints can be widened. The overall level of chronic tension can be diminished.

Repatterning techniques are almost wholly a contemporary invention. One finds next to nothing like them in either the European or the Asiatic massage and pressure point traditions. (I will talk about pressure techniques, which are executed differently, in a moment.) The systems developed by F. Alexander (the "Alexander technique", Alexander 1938), G. Alexander (1986), Feldenkrais (1970), and Trager (1987) are prominent examples.

My own preference, for use in a body psychotherapy context, are the "hands-on" repatterning techniques of Feldenkrais, with whom I had the opportunity to study. I must clarify, however. Many persons today have heard of a series of yoga-like exercises known as "Feldenkrais exercises". These were indeed created by Feldenkrais, who was arguably the most fertile of the modern innovators in the body disciplines. A person does the exercises by herself/himself, or in a class led by a teacher. But Feldenkrais also developed a second form of physical work, an ingenious "hands-on", one-to-one mode (i.e., a practitioner works upon a client). It is this second form, less widely known, to which I am referring.

For body psychotherapy, these gentle, subtle hands-on techniques of Feldenkrais have a number of advantages. For one thing, they don't hurt. There is no digging painfully down into

the patient's deeper tissue layers, as is done with most pressure techniques (see below). Instead the patient merely experiences how the therapist lightly maneuvers perhaps several ribs; or a part of a limb; or a vertebra; etc. The practical effect is a minute relearning which takes place in the nervous system. The brain messages travelling to selected muscles, the signals which tell a muscle what level of tonus it should maintain, are altered. (The actual causal reason why a muscle stays bunched up in a contracted state is because the brain fires a constantly-repeated demand it should do so. A muscle which remains in a hypertonic condition is simply following orders from above.)

Afterwards, once this muscle and some of its neighbors have changed their state, a wider range of movement in the nearest joints will be evident.⁸ The patient will be aware too of more differentiated sensations, and of more perception of movement possibilities.

Another advantage is that repatterning techniques don't require a state of undress. As I have already said, some patients are comfortable, when it comes time for the physical work, with changing to (or peeling down to) a swimming suit, a gymnastic outfit, etc. But there are plenty of others who would poorly tolerate being only half-clothed in a therapy setting. They often do the physical work in either their street clothes or a bulky jogging suit, for example. That poses no problem whatsoever for these physical manipulation techniques. It is a form of "hands-on" work which can be done with (i.e., through) however

⁸Feldenkrais incidentally was an accomplished mechanical physicist before tackling the conundrums of body-work. A hard-headed scientific orientation -- tissue and bone as cord, levers and pulleys, so to speak -- guided the growth of his approach from start to finish.

many layers of clothing.

What is the point of altering the level of tension in a patient's neck? Or the position in which his shoulders come to rest? We are talking about psychotherapy, remember, not marginal increases in bodily comfort.

The long answer to that question will come later in this book. We will need first to look at some implications of recent infant development research, and then take up the poorly-understood topic of body defenses.

But here is a short answer. First, any significant diminution, even if temporary, in the overall chronic body tension, will usually allow a richer body process to emerge during the session. Second, subtle motor preparations which lie outside consciousness play a tremendous role in structuring both our interaction with others and our contact with ourselves. There exists a bodily intersubjective field, if you will, a kind of stage setting we secretly prepare before the curtain goes up and the play begins. (About which more later). The benefit to psychotherapy of a reduction of chronic muscular holding patterns lies in its potential effect upon that field. Alternative modes of organizing the field are made newly possible.

Pressure techniques.

Pressure techniques rely upon hard, concentrated force. Using a thumb tip, a knuckle or even an elbow, the therapist presses deep into the patient's muscle tissue and/or connective tissue. Usually it is a rather exact point which receives the

pressure. Tight and knotted tissue is stretched and lengthened.

There exist a number of "body-work" approaches which systematize such techniques. Rolfing (created by Ida Rolf (1977)), shiatsu (a centuries-old japanese method) and "polarity therapy" (a set of techniques (Stone 1963) which migrated from India to the USA) are three of the better ones. Though mostly I prefer repatterning techniques for re-structuring the musculature, on occasion I draw upon these other approaches too.

Their advantage is they can fairly quickly release tissue from a contracted condition, especially in certain body locations. Their disadvantage is they often hurt. (Their purpose is not to hurt; any pain is just a by-product.) For some patient that presents no problem; the patient right away "understands", on some bodily level, what the technique is all about. But for others the idea of experiencing physical pain in a therapy setting is simply too much. Pain is the last thing they want there, whatever its intended purpose.

By the way, pressure techniques, sometimes also called "deep massage", have little in common with massage proper. Massage, in the more ordinary meaning of the word, consists of kneading the muscles, of long smooth gliding strokes with the hands, and the like. Though enthusiastic about massage in other contexts I don't advocate it at all for body psychotherapy.⁹ First because, although it temporary relaxes, massage leaves no enduring re-

⁹In the seventies at Esalen Institute I taught many body awareness workshops in which, along with other body disciplines, some brief massage training had a frequent part. Although in this case the setting had nothing to do with psychotherapy, I had the opportunity to witness a large number of people report about their personal reactions to diverse forms of body experience and "body-work", massage included.

organizational shifts in the musculature. Second, because it remains somewhat sensual however professionally done. That can easily introduce unnecessary complications into the transference relationship. Finally, there is no need. For increased contact with the body, for exploration of regressive states, etc., the other physical techniques quite suffice.

Respiratory techniques.

Of all the physical techniques I use, these are the most important. They are designed to alter not only how one breathes, but also how one lives and experiences breathing. They stand at the core of the physical side of the present method.

In part these respiratory techniques overlap with the other techniques. For example, certain repatterning techniques have as their specific target the unlocking of muscular constrictions which impede breathing. (Feldenkrais, for example, was particularly attentive to respiratory functioning. He always had one eye on it. A number of his "hand-on" maneuvers reflect this.)

But there is much more to altering respiration than a freeing up of tight muscles. That is just a beginning. Breathing is a cycle of movements. When we breathe we act. These movements themselves, these patterns, must also undergo radical changes. Yet even to say that falls short of describing the most fundamental goal: to transform how the patient personally engages himself with his breathing.

Attention to respiration begins almost at the start of the therapy, long before the phase in which explicit physical tech-

niques are introduced. Initially this is achieved through experiential interventions. At strategic moments the patient is invited/requested to focus upon how she senses her breathing; or upon what her breathing seems in the moment to be doing; or even upon what it seems to "want" to do. (The lattermost implies of course that it might "want" to do something other than what it in fact at the moment is doing.) Used judiciously, such interventions will of themselves bring about a more differentiated sensing of the respiratory impulse.

The actual respiratory techniques -- which are physical interventions -- then serve later as a continuation of this current. There are different subtypes.

Some respiratory techniques, for example, start off as a kind of exercise. A client might be instructed to breathe for three or four minutes using a certain particular breath-movement in his abdomen. And then for a few minutes using another particular breath-movement in his chest. In a more elaborate version there might even be several minutes more where he alternates between the two movements, switching from the one to the other with each new breath cycle. All of which is rather mechanical, both in reality and in its feeling for the patient. But it serves very well as a lead-in to, a preparation for, further work with a body process. It enriches ahead of time the process which subsequently will emerge. In addition, the patient will soon discover his respiratory pattern re-structured, temporarily, in some interesting way. (His lower ribs, to take just one example, might be delicately fanning out with more movement and with a new sensitivity along the sides of the torso.) That too is an important form of learning. Repeated exposure to novel respiratory experiences helps create the conditions for a metamorphosis of

the patient's most basic relationship to his breathing.

I draw upon a quite ample repertoire of these re-structuring respiratory techniques. Some come from non-therapy body disciplines, some belong to the body psychotherapy tradition, a good many I have developed myself.

A second subtype has already been mentioned: repatterning "hands-on" techniques specifically intended to re-organize respiratory functioning. In addition to those of Feldenkrais, some of the respiration-oriented repatterning maneuvers I find most effective are ones first systematized by Proskauer (1968) and Middendorf (1987). In some sessions I use primarily such repatterning techniques, in other sessions primarily the re-structuring exercises. Frequently I use a combination. (Of course there are a certain number of patients who prefer to have no "hands-on" work whatsoever. In this case we use exclusively the re-structuring respiratory exercises. That, and many experiential interventions focused upon the breath.)

The exact physical interventions a therapist makes with a patient's breathing is based upon what we call her or his, the patient's, *respiratory profile*. This means simply the details of how her/his respiration habitually functions, as seen from the outside. Where is the breath more constricted, where more free? What is its tempo, its volume, its co-ordination (abdominal movement integrated with chest movement), its degree of fluidity (jerkiness vs. smoothness), its degree of differentiation (fine movement vs. wooden movement)? What takes place during the transition from inhalation to exhalation? What during the transition from exhalation to inhalation? And so on. There is a great deal to analyze here; I am just touching upon the subject. Every one of us has a breathing problem, or rather a row of prob-

lems. This superb instrument, our respiration, in older children and in adults exists almost in a state of ruin.

The goals of re-organizing respiratory functioning are diverse. Most obvious is the mechanical goal. The habitual patterns must change; usually extensively, and usually in a number of dimensions (co-ordination, fluidity, etc.). Eventually even when a person is asleep his or her breath flow will function differently.

Like almost every other body psychotherapist I subscribe to the "downstairs-upstairs" school of thought about respiratory functioning. The breath (more exactly the respiratory movement) when it is functioning well starts to spread first in the pelvis and then climbs lightly (or during a moment of exertion more strongly) into the chest. (From this point of view the singing teacher and the zen instructor who help open up abdominal breathing, and that only, are seeing just half of what needs to be done. And the aerobics teacher who proposes one flatten the stomach and huff and puff in the chest is giving advice so mistaken it borders on the macabre.)

These mechanical goals then serve as a base for other purposes. More critical for the present method, as a part of and an aid to psychological change, is the patient's inner experience of her or his breathing. New habits of attention must be added to the new motor habits. The patient must develop a special skill difficult to describe in words. This is the ability to maintain, wherever else one's focus might be centered, a marginal consciousness of breathing. There at the edges of my world is my respiration: what is it doing now? A path for a lifetime, but therapy can start one down it.

The rationale for cultivating this on-the-margins sensitivi-

ty is a complex one. Physiologically the breath is a kind of pump, feeding and driving other physiological systems. But psychologically it is a kind of radar. It is as if an instrument of perception.

This is because the respiratory system is so intimately intertwined with our affective states. Change the immediate condition of our emotions -- change the barest nuance only -- and our breath flutters or swells or hesitates or otherwise responds. Nothing else in us reacts with such fine calibrations. And since our affective states are a way of disclosing our surroundings, that can be critical information. Simultaneously as affects read the world the breath reads affects. I will return to this point.

Vertical alignment techniques.

These are techniques used to alter what we might call the act of verticality. Each of us whenever standing upright must implement dozens of minute unconscious readjustments. The toes reshape themselves now one way now another, the neck and the pelvis too, etc. These positionings are forever in flux; our balance is constantly lost and refound. Naturally the same is true if we are not standing still but moving about. Even our breathing patterns become slightly different whenever verticality must be maintained.

Alexander Lowen (1958) was the first to focus in a therapy setting upon this aspect of bodily being-in-the-world. He came to speak about "grounding", a seminal concept. Clients were said to be poorly grounded, well grounded, etc., depending upon their ability to align their bodies so as to make an optimal use of

gravity. (Lowen also developed a theory about what on a body level is happening when a person is well grounded. At the center of this theory is the notion of "energy". Lowen claims, e.g., that "energy" should be flowing, to a maximal degree, down the leg, through the foot, into the ground; and then back into the foot and up the leg again. I find this explanation needlessly esoteric. One can reject the questionable metapsychology (metabiology?) however, and still recognize Lowen's brilliant discovery of an entirely new technical direction.¹⁰)

For working with vertical alignment Lowen also developed a number of particular techniques. "Stress positions" they are often called. The client stands, and then he places his body in a posture resembling a kind of upright yoga position. For example, he might arch backwards with the pelvis bowed forward. Then he starts rapid, deep breathing. This stretching of -- or stressing of, ergo "stress positions" -- certain muscle groups leads very quickly to a condition of fibrillation (i.e., trembling). In other words, it is a more rapid entry into what I have called the stage of trembling in a body process.

I use such stress positions occasionally, and find them helpful. But they have two major drawbacks which should be noted.

One problem is that they induce a body process so extremely quickly, and that the process elicited is often so forceful. This is the difficulty I mentioned earlier of a technique working "too well". On a scale of emotional intensity from one to ten the client zooms from zero to seven or eight in minutes. That just is not the way to go with a good many clients. And espe-

¹⁰For a more extensive critique of energy models see chapter 26.

cially not in the earlier stages of the therapy.¹¹

A second problem is that stress positions create very little room to work with the subtleties of alignment itself. The client is so busy shaking and vibrating and emoting that he or she can hardly be expected to turn his attention to the finer points of balance, or to how body part A might explore some new positioning with respect to body part B. Nor can the therapist now use her or his hands with any precision. Surprisingly, "grounding work" which is based upon stress positions actually exploits few of the available possibilities for improving the patient's grounding.

For these reasons I have come over the years to develop a number of alternative ways to work with the body in vertical positions. Slower, quieter techniques for the most part, some utilize the therapist's touch and some are independent of that. The focus then becomes more one of perceiving balance (or lack of it), making adjustments which alter the relation to gravity, re-organizing how the breath shapes vertical inner space, and the like. Often techniques of the other types already mentioned are here brought into play too, but now with the aim of introducing change in those bodily schemas which govern vertical alignment. (What are called internal techniques, described below, also play a frequent role.)

To take a particularly simple example, a patient might stand with his eyes shut and talk about some of the details of how he now perceives his body, his breathing, and the flow of minute muscular acts required to maintain equilibrium. Then, with the patient's I might use my hands to introduce slight changes of

¹¹Lowen's view is the opposite. He has frequently (e.g., Lowen 1958, 1967) proposed working in this fashion right from the first session of therapy.

alignment. Using modified repatterning techniques, for example, I might temporarily ease a holding pattern in the upper spine. Then I might delicately sway the patient's body in a barely visible movement, allowing other body parts to feel out unhabitual alternative ways to participate in the overall balance.

You might think that to proceed in this more delicate manner would preclude contact with emotions. Interestingly, the opposite is the case. A not infrequent result is an emergence of both affects and childhood memories. They tend to make themselves felt more gradually, however. And often the quality of emotion is more contained than outwardly expressive. Nevertheless the client will likely experience this emotional quality as tangible and vivid. And it can lead, if he so wishes, to further exploration, both verbal and/or with the body.

Internal techniques

These too are techniques I use often. I have waited to mention them because, although they are difficult to describe, that will be easier now that we have gone through some of the other types. The operative distinction here is between internal and external techniques. All the forms I have talked about up to now are external.

I call a technique "internal" when (a) it directly unfolds something already taking place in the patient's immediate bodily experience, and (b) chiefly it is the client himself who does the unfolding, though with guidance. The previous techniques we have seen work mostly outside-to-inside, one might say. The therapist

has his or her program and he/she imposes it. Internal techniques work inside-to-outside. A very different affair.

We begin, in other words, with something the client is already sensing in her body. Or already doing with her body. She may have reported it spontaneously, or she may have come across it in response to an experiential intervention from the therapist. Either way, what she is sensing can now be amplified and explored, bodily.

The starting point, for example, might be a movement or gesture the patient has discovered he is making. One patient, sitting, began tapping a foot lightly against the floor. I called his attention to this and proposed he sense exactly what the movement felt like to him. He discovered in it an urge to press his foot firmly into the floor. Doing that, he next wanted to stand, and did; and then began to explore a particular quality of standing, a wished-for quality. This lasted some minutes. What crystallized was a kind of resolved, firm, this-is-my-place-and-here-I-am manner of feeling his body and the floor under him. It seemed to him unfamiliar, yet something that he had been seeking. The session continued both with additional physical work with vertical alignment and with a confrontation with some relevant themes from his childhood history. Naturally this entire exploration, with its taste of the new, in a sense continued and extended work done in previous sessions. It didn't come out of the blue. Yet it did come out of the blue, in being at that moment wholly unplanned.

It took me a good many years of working with the body to appreciate the enormous potential embedded in these spontaneous self-reorganizing bodily impulses. They do require encouragement, support, guidance. Yet that is a very different way to

proceed in comparison to the other techniques listed above. In this case the therapist must assume that the body now knows, somehow, what exploratory program to execute; even if he himself, the therapist, is in the dark about the nature of the program. One must rely upon a kind of free associating of the body itself.¹²

* For the therapist, this greater open-endedness, with its inherent ambiguity, can be disturbing. Doing supervision I have noticed how some therapists easily become nervous when trying internal techniques. They want to hurry up what is happening, and push the patient. Or they force the patient prematurely to define in words what she is doing and where she sees the process heading. The waiting and the indeterminateness are skipped over. Often a therapist must have much repeated contact with these techniques before he or she learns how thoroughly one can count upon the body.

Internal techniques, by the way, are often the best of all for working with severely disturbed patients. Occasionally for a long phase in the therapy they are the only way, beyond experiential interventions, to reach the body. And for good reasons. First, many of the internal techniques require no touching. Second, the patient himself is plainly in charge of the unfolding. The progression is slow. He alone is choosing at every point that it continue. For a patient with sharper than usual worries about autonomy, and about the threat of control by the other, this is reassuring. Third, these techniques can be connected so closely to a preceding verbal dialogue. The patient experiences them almost as an extension of his discourse; the

¹² A like comparison to free association was once made by Ferenczi (1955).

weave is tight. For a severely disturbed patient this too is reassuring.

Internal techniques come in many shapes, sizes, variations. One productive version, for example, involves guiding the patient through a body experiment in which he actively varies the level of tension in a selected muscle group. "There's that clenching of your teeth again, can you feel it?...Could you try clenching them the tiniest bit tighter, and see what you experience while you do that?", etc. In this example the basic idea is slightly to exaggerate the muscular holding. Several steps further in the same direction could also be explored: "Now try clenching them even a little more", etc.. The patient then reports what he feels with each step.

This will sometimes lead to quite interesting developments.¹³ And on virtually any of the levels of consciousness. A memory might be loosened; a thought, a new motor impulse, whatever. Productive too can be the moment immediately after the patient relaxes, letting this clenching fade away. Sometimes it is then that a new motif swims into consciousness -- again, on any level. Also possible is to have the patient do the letting go, the relaxing, in gradual steps. She once more examines what emerges in her at each point.

Other variations utilize the therapist's physical touch.
For example, the therapist provides countermovements which appro-

¹³The genealogy of this particular form of intervention is an interesting one. Ferenczi (1955) appears to have been the first to use it. Perls (1969), who was once Ferenczi's patient, made it more sophisticated. Although Perls never branched out into body psychotherapy proper, he often worked very close to the body. Keleman (1987), taking this technical line still further, has developed a rich, ingenious version which he employs as his primary mode of intervening in a therapy.

priately complement the patient's emerging movement -- e.g., the patient wishes to push, so the therapist with his hand provides a barrier against which he can do so. Especially Pesso (1969) has creatively extended these technical possibilities.¹⁴ Another use of the therapist's touch I sometimes call kinesthetic eliciting. Here the movement is amplified by a light physical guiding from the therapist.¹⁵ A client might be making, half-consciously, a minute rhythmic back-and-forth movement with one forearm, for example. The therapist might delicately place one of her own hands, or even just her fingertips, against the patient's forearm. Then by means of a barely perceptible guiding pressure she (the therapist) can "talk" to the arm, encouraging it to widen its rhythmic arc. This can be quite effective. The trick is for the therapist not to predetermine exactly what form of larger movement will then emerge. Instead she must tune in very carefully by means of her own touch. She must read the kinesthetic signals, letting the patient's arm itself "talk back" however it wishes.

The sheer amount of movement unfolded by an internal technique also varies a lot. This depends upon the technique itself, upon the patient, and upon the general inclinations of the therapist. And naturally too upon the layout of the office. If the open space is there and if he is encouraged to do so, a client may once in a while may move about more expansively in the room, shifting into a kind of full-body movement, a kind of dance

¹⁴Pesso's work, which is designed for group settings, is a little like psychodrama done as movement. A number of useful countermovement maneuvers suitable for individual therapy have also been shown by Mindell (1982).

¹⁵Particularly interesting versions of this technique have been developed by Boadella (1987).

expression. Often body psychotherapists who work a lot in that way have some background in what is called "dance therapy" or "movement therapy".¹⁶ This is a special direction with its own interesting potential. On the other hand many important explorations are so minute, spatially speaking, that the therapist watching from outside can only barely grasp what is going on. The Chinese have an ancient saying: one inch at the center of the body is the equivalent of ten thousand miles at the circumference of the earth. Patients who work with internal techniques discover for themselves the truth behind that maxim.

Not only do there exist many forms of internal technique; the possible moments when one could use them, in work with any patient, are plentiful. Of course the therapist has to build up his experience. But once his eye is trained to watch and his ear listen, feasible entry points show up continually, moment by moment almost. One could not possibly use every inviting body signal; nor should one try. Like any of the physical techniques these should be used selectively. But the chances when one could do so are nearly always at hand.

That is, in part, because a transition to an internal technique can be made starting out from any of the five levels (chapter 5) of consciousness. In training I call these "cross-over opportunities." For example in the case mentioned above (the patient tapping his foot against the floor), the beginning point of our exploration was on the movement level of consciousness. But cross-over opportunities show up just as often on the other levels of consciousness. When a cross-over point is selected

¹⁶A few therapists I have trained have very nicely integrated this style of work with the rest of the technical approach I advocate. For good overviews of dance therapy see Chodorow (1991) and Stanton-Jones (1992).

with care, and the timing is also right, the patient will experience a nearly seamless glide from word to body.

Sensations can be a gateway, for instance. A patient reported a strong peculiar tingling around one elbow. A "buzz", he called it. I encouraged him to stay in contact with this, and see what wanted to develop. The tingling spread a little, the arm began to vibrate. At first I thought probably this was only the onset of a tetanus physiological reaction (when the hands tighten, c.f. chapter 4), even though his breathing at this point was subdued. But it failed to show up in the hand, let alone become centered there (as would happen with a tetanus reaction). Nor did he experience any tightening or spasms. On the contrary, soon he found his arm and hand wanting to move in space, and with a particular quality: slowly and sensitively, and in an out-stretching direction. After repeating it several times he had the idea that with this gesture he was offering of himself, giving of himself, to someone. That in turn elicited sadness in him, and further reflections; this being an area of life in which for some time now his deficiencies had been a source of preoccupation.¹⁷

Images too can provide the point of transition. The client may first see herself engaging in some bodily action; she may visualize it, spontaneously, without as yet perceiving any kinesthetic motor impulse. One can then propose that she explore, if willing, the motoric analogue to the image. A more complicated version of this cross-over procedure can also be applied to the

¹⁷For a nice example, in a Gestalt therapy setting, of a similar progression starting from sensation see Polster (1970).

remembered images of dreams.¹⁸

Or the patient may have an image which potentially could elicit some bodily response in reaction. One client, exploring a series of associations, had an image which scared her. It was of a masculine figure vaguely threatening of both sex and violence. She couldn't make much sense of it in this session; the relevant history, which concerned abuse by a stepfather and which had been quite fully repressed, came to be known only later in the therapy. But we were able to do some helpful work on the spot using internal physical techniques. She felt out her bodily responses to this image (freezing, constricting); felt out alternative responses (active protective ones, some involving pushing her arms out and some involving an activation of her legs in readiness to run); and then allowed a little further contact, in small steps, with the connected emotions. None of this required her to leave the chair where she was sitting. Yet the exploration was thoroughly bodily. This and similar sessions provided us with a good preparation for work later in the therapy with a terrifying central theme.

Notice, by the way, how close the internal techniques lie, in general, to experiential interventions. There even are some techniques one is hard put to say to which group they belong. I find it best to think of a continuum. At one far end we find experiential interventions. They bring the patient more in touch with the body, but through a verbal exchange alone. Somewhere in the middle of the continuum are the internal techniques. The patient is now more active, but he lets his body itself determine

¹⁸Work with dreams, which "speak" incessantly about body history and potential body re-organization, is a special topic in itself, here regretfully left to one side.

the exploratory program. At the other end are the various external techniques. In their case it is the therapist who chooses the program, at least in the beginning of their execution.

Helpful too is to think of a second continuum. Internal techniques also shade into the next technique type to be discussed, what I call the affect techniques. As we have seen, an internal technique often leads to the patient's feeling her way into a movement, be it minute or expansive. But at a certain point that movement may take on some affective coloring; and it may then evolve into an overt expression of affect. What started as a blink of the eyes may end in moisture and tears. Not necessarily, of course; but on occasion the progression is like that. So it is useful as well to keep in mind this second continuum: the internal techniques at one end, the affect techniques (described below) at the other end, and many intermediate steps in between.

Affect techniques

These are techniques for the discrimination, expression and re-organization of affect. (To repeat, I am using the terms 'affect', 'emotion' and 'feeling' interchangeably.) In chapter 3, which recounted a session with the patient Robert, we saw an example. Robert was experiencing feelings of longing, of yearning, in his chest. He then physically reached out into space with his arms and hands. The act of reaching strengthened the longing, and there came overt sobbing in its wake. Another example is a patient who, feeling angry, strikes with a fist or

leg against the mattress.

Perhaps there is no subject more confusing than the role of emotion in therapy. What seems best to do is this. Here I will simply give a brief overview of some affect techniques, and of how they fit into the flow of a session. As we go on I will at times return to the topic, however. We will look at it from the angle of infant development research; and later still, in the context of therapeutic work with regressive states.

First, let me review a point mentioned earlier. For the present method the bodily expression of affects is strictly a subordinate goal. It is an option. More primary are three other technical steps.

Task one is clear perception. Sensing the affect; letting it impinge, bodily. Included here is the patient's noting of the exact subjective bodily location -- a sadness or anger registered in the throat, or the arms, or the abdomen, etc. At this location it will have some particular and distinctive feel. There will be a constellation of physical sensations plus something more, a sensation-mixed-with-affect combined quality.

Task two is labelling¹⁹. A simple project for most patients, but a surprisingly hard one for a few. Suppose a patient is working with the body and an emotion makes itself felt. The patient then needs to come up with some word or phrase which describes the emotion, some appropriate tag. "I'm feeling sad." "I'm feeling hopeful." "I'm experiencing a kind of anger with a pleasant edge to it."

Task three brings up the question of reference, of

¹⁹By speaking as if clear perception and labelling were two independent tasks I am oversimplifying. In reality to be engaged in either one is already to be in some degree engaged in the other.

"aboutness". Of the three primary tasks this is the one which is often difficult. What is this sadness, fear, joy, or whatever about? What is, as the phenomenologists say, its intentional object? Does the patient know at once? Does she or he have words or images? ("I realize I'm angry about something A. said to me last week." "I'm seeing an image of my first grade teacher.") If not, the therapist may well encourage her/him to probe further. The therapist might even aid with a specific intervention or two (as discussed in the previous chapter). The goal at this point is not an elaborate investigation of the referent, but simply a first glimpse.

These subgoals are the principal ones. Once they have been achieved, then the matter is open. Should the emotion be explored further, or not? If yes, then through a verbal investigation? Through a bodily exploration? Or through both, carried out more or less simultaneously?

If the patient elects to continue with a bodily exploration of the emotion, and if the therapist has no reason to dissuade her or him from that, then a new undertaking is in order. This is the affect expression option. One or more affect techniques may now be used to deepen the patient's contact with the emotion.

However, there are more helpful and less helpful ways to go about that. I am quite against what I have too often seen done at this point: the therapist now pressures the client to throw himself into an immediate and intense physical expression. Frequently as well, in the same intervention, the therapist also dictates which bodily movement should be used.

My suggestion is another one. Moving rather more slowly, the therapist instead should help the client to feel out and

clarify several points.

(1) For the patient himself or herself, in his/her experience of the moment, what type of physical movement would most accurately correspond to the characteristics of this felt emotion? The idea here is not yet to engage in the movement, but first to sense, to feel out, what it might be like. Interestingly, when patients are allowed to probe the feeling/motor movement connection in this way, the range of what they may come up with is quite broad. Often the connection will be an obvious one: the patient feels anger, and the movement which she or he senses would now fit is a clenching of a fist, or scowling in the face. But at times the patient will surprise you: he feels anger, and the connected movement turns out to be, e.g., a quirky, idiosyncratic jerking to one side of his head and neck. Or a pushing with his left (but not his right) knee. Any part of the body can in these moments be brought into play.

(2) Once he has pictured the movement which seems to correspond to the affect, how natural or foreign does this movement seem to him? If he contemplates the prospect of actually engaging in it, does it seem to him relatively familiar, trusted, a "normal" part of his affectmotor repertoire? Or (as may be the case) the opposite?

(3) How much anxiety is concomitantly present in him?

(4) Now comes the most critical component. Suppose the patient's anxiety level is high. Suppose he would like nevertheless to continue the bodily exploration (a frequent state of affairs). One then helps him determine the following: what then could be a limited piece, a slice, a mini-segment of the imagined movement? What portion of it might he actually initiate without too greatly raising his level of anxiety?

I call this work with microexpression and I make extensive use of it. It is the path of the smallest possible jump. Let us look at an example. A patient working with a body process came into touch with a trace of anger. Markedly phobic about anger, she had reached exactly this point in other sessions and then had always stopped. Today, however, she stated a desire to continue, bodily, a little farther. The therapist agreed to help.

First the therapist assisted her to clarify what bodily movements might best fit the feeling. The client reported several possibilities, including the idea of striking out with her fist. Saying this, however, she looked visibly agitated and scared. So the therapist now aided her to choose a mini-segment of the expressive movement, one which he would be likely to find more manageable. What they together determined was that the patient should just draw one hand into a fist, that and nothing more; and see what this was like for her.

I am aware that to tell it this way may sound trivial. Only to shape a hand into a fist -- it is a limited gesture certainly. Yet senseless it is not. On the contrary, for patients highly phobic of anger this often feels like a dramatic step. The reason is that the forming of the fist more strongly activates the motor system. More exactly, whenever we feel an emotion some tiny changes are already occurring in certain muscle groups (Bull 1968). These changes are minimal, however, as long as the muscles perform no overt action. However, even just to tighten one's fingers and thumb into the fist -- an overt action -- instantly changes the level of overall activation. It mobilizes a higher state of emotion-in-conjunction-with-musculature readiness; the combined system is now more strongly poised. And this the patient will subjectively sense. It may frighten him, it may

excite him, but one way or the other (or both simultaneously) he will have a reaction.

The advantages of proceeding in this fashion are several. For one, both client and therapist now have an opportunity, before anything else happens, to evaluate the patient's immediate reaction. What was it like for him to explore this step? How much anxiety came with it? How much satisfaction? Second, so to proceed maximizes the atmosphere of choice. The client feels in control of the situation. She can pick the dosage, can find out with deliberation just how far she wants to go. (Is this step enough for today? Or does she want to go on to another?) Third, the accent now falls upon what the patient in fact do, and not upon where she falls short. She feels effective. She has made something happen. Instead of berating himself (or worse, being berated) for being "out of touch" or "blocked" or otherwise affectively maladroit, he experiences his competence. A domain of agency where she thought to have none has been uncovered.

Suppose now that the same patient also wants to continue a little more. He and the therapist can then determine a new trial step. This will be another mini-segment of the same affect-movement constellation. The therapist might propose, for example, that the patient again clench the fist, and then, moving just from the elbow, swing it a few times lightly up and down, and with each downward movement bring it into contact with the surface of the mattress. The patient after trying this can again report what he experienced doing it. And then he can newly decide, with clear deliberation, whether to close the exploration or carry it still further. (If further, more steps can then be added. See below.)

Suppose on the other hand the patient finds it too difficult

to make the fist in the first place. What if even this mini-segment turns out to be too large a jump? Let me assure you that sometimes occurs, for example with certain very timid borderline and psychotic patients. What then?

The solution is simple. One finds a still smaller mini-segment. That is in fact the answer anytime the client both wants to go on, but cannot manage with an already proposed step. In this example, the logical alternative would be to suggest that the patient not actually form the fist with his or her hand, but instead just imagine he/she is doing so. This is a move I have made many times with clients of this type, and it has almost always been successful. The level of threat is reduced; yet at the same time, by performing this act of imagination, the patient experiences himself as having genuinely made an advance. As indeed he has. So to picture the hand as curled into a fist will in fact produce a slight neuromuscular change: the act of imagining, as research has unambiguously documented, creates marginally higher levels of preparatory activation of the muscles.²⁰ Any patient who in several sessions can reach this point will before very long afterwards be ready concretely to make the fist. That is one benefit; a second, again, is the patient nascent sense of mastery. Her or his experience could have been: I wanted to try making the fist but I failed. Instead her/his experience becomes one of finding a step which succeeded.

Needless to say, when working with microexpression the

²⁰A well established correlation. Shaw (1940) for example had subjects first lift weights of different heaviness. Afterwards, while being tested for muscle potential levels, they were asked to imagine lifting the weights. The patterns and degree of activation in their forearm muscles reflected the varying heaviness of the different imagined weights. (C.f. P. Lang 1984).

therapist's tone is crucial. His or her comments and manner must be non-judgmental. Now is not the moment for observations such as: "why are you holding back?", or "you are being incongruent", or "your voice and face don't seem to fit with what you say you are feeling", etc. The therapist must appreciate too that the patient's universe is not necessarily identical to his/her, the therapist's, universe. For many patients affect microexpression will feel like a risk. A manageable risk, once the right moves are found; but a risk none the less.

Of course some patients at some times will have no need to linger with minimal steps of this type. A patient might be largely comfortable with emotions of anger, for example. Perhaps she always has been so; or perhaps previous work of the kind just described has brought her to the point where she is impatient now to pass on to something more. That is fine. The patient is welcome, if she wishes, to experiment with fuller expressive movements.

One alternative in that case would be to determine new mini-segments which encompass more expressive action than the previous ones. To stay with the example from before, additional steps could be as follows: swinging the fist, from the elbow, somewhat harder onto the mattress; swinging both left and right fists simultaneously; moving one whole arm from the shoulder, bringing the fist down now with more impact; moving both arms from the shoulder; and the like.

The other alternative is that the patient simply forget at this point about chopping up the action into mini-segments. If her wish for expression is sufficiently strong, and her nervousness about it sufficiently low, she can then try right off the bat to engage in a stronger or more fluid movement. For example,

to hit vigorously against the mattress, along with forceful vocalizing, might be an expression which (a) scares her very little and (b) truly corresponds to the level of emotional feeling in her at the moment.

This question of "correspondence" to the inward felt emotion is quite important. Often a patient will make a smaller, more muted physical expression of an affect, not at all because he is scared, but just because that is the degree to which he is experiencing the affect. Of course, the physical expression may in turn make the affect inwardly stronger, subjectively speaking; and then the physical expression in its own right may become more intense. But at times it does not go like that. The patient may inwardly feel only a low or medium temperature of affect; he may then physically express only a low or medium temperature; and then the experience is over. Which too is quite o.k. A therapist working with the present method is very careful to convey to her clients that small scale emotional expression is just as valid, and just as therapeutically useful, as large scale. This message puts the emphasis upon the client being honest to himself, and supports him in avoiding artificiality.

The purpose of the use of affect techniques, to state the matter on a more theoretical level, is not discharge for the sake of discharge.²¹ The purpose is to help the patient build up a more differentiated bodily familiarity with particular affectmotor schemas. Anger-together-with-arm-hitting, for example, represents one such schema. There exist many others. (The

²¹I think it is a misunderstanding to imagine that within the client there exists a kind of well of stored-up affect; and the client needs to liberate himself from this burden, he needs to get it "out". Much to be recommended is Schafer's (1976) long and thoughtful critique of what he calls the "storage reservoir" image of emotion.

concept of an affectmotor schema will be discussed in depth later on.) The patient must get to know this schema; and in her getting to know it, the schema itself will also evolve. But that however implies considerably more than her acquainting herself with high intensity expression. Equally important are new skills in differentiating and expressing more nuanced affective states; intimacy with the full range must be built up. We would not want to teach someone to play a musical instrument at only the loudest possible volume.

Needless to say, a similar use of microexpression can be applied to other domains of emotion too, not just anger. Take sadness, for example. There are a number of possible segments. For example, forming the smallest beginnings of a sad expression around the eyes. Forming the smallest beginnings of a sad expression around the lips and mouth. Forming more pronounced, more defined sad expressions of the face. Adopting the beginnings of what would be, for the client, a postural position which for him fits the sadness he feels. Adopting more degrees of the same posture. Feeling the eyes -- just that alone (surprisingly effective). Feeling the eyes, and imagining they could become wet. Making a quiet, brief vocal sound several times. Making a few vocal sounds which capture still more of the quality of the sadness. And so on.

* | All such affect techniques, by the way, I use only when the patient is already in touch with a trace (or more) of anger, sadness, fear, etc. In other words, I do not advocate introducing such techniques when the patient is in a neutral state in order to "induce" some particular affect which the therapist would prefer him to be feeling. There is no need of that. If one works with the body an emotionally frozen client will un-

freeze in his own due time. Given that the therapy continues, this is virtually certain. And over the long run a client will feel his autonomy more respected if the affect techniques are limited to explorations of emotional states already present and conscious. That lets the patient be more in charge, and he will be very aware of it.

Chapter 8

ENCOUNTERS WITH THE PAST

We seem to have at least two different memory coding systems. One is more closely linked to the body than to images and words.

I have already mentioned perhaps the most remarkable fact about working directly with the body. If the therapist opens up the patient's breathing, that stimulates a "body process". And if the body process continues a while, there come memories, along with connected affects.

But what kinds of memories?

I was working with a woman. We were around six months into the therapy. We had already started with the body since several months; there having been, in her case, no need to wait a long time. She was a solid person, a seasoned psychiatrist who had already had some previous good therapy.

One day, while she was working with her breathing, something unusual happened. She went into a particular state; a remark to the effect "I am feeling very small" was the signal.

This in itself was nothing unusual. She was a client who could be expected to move right along in therapy. "Feeling very small" is one of the typical indications of an emerging body regression. The past was knocking at the door, as was to be expected.

But the more the state evolved, the more idiosyncratic it became. You come over the years to see certain patterns in regressive states. There exist a lot of variations, but they do group themselves into recognizable profiles. I had never see anything quite like this, however.

Her arms shot out at a peculiar angle: to either side, rather like the hands of a clock at ten and two if you think of her head lying at twelve. Her arms were stiff and straining. She became furious. She said they couldn't move. Her head was mobile, rocking slightly from side to side. Her legs too appeared restless and agitated. But her arms stayed rigidly in place. Testing the movement of one (I just held her elbow where it was and manipulated the forearm) I found it could shift its position with no real problem. Still her strong phantasy was that the two arms couldn't budge.

We tried to explore associations. Nothing. I tried to help her get in touch with motor wishes, with a motor sense of a phantasized situation, and the like. (These are technical steps which will be explained in a later chapter). We got nowhere. Frustration built up in both of us. The state was so distinct, so defined; yet bafflingly elusive.

Three weeks later the same condition repeated itself. This time the experience was briefer. And a desperate crying replaced the feeling of rage. Otherwise all was as before. We couldn't make sense of anything.

Until some days later, that is, when she walked in and proudly announced she had solved the puzzle. And she had. Her parents had just visited for a weekend. On a couple of long walks with her mother she had managed to engage her in a lot of discussion about her, the patient's, childhood. A piece of vital information which she had never known had come out.

In her infancy, from age seven months to eleven months, she had suffered from a extremely bad case of eczema. As was sometimes done in those days, the doctor treating her had insisted that the family keep her arms encased twenty-four hours a day in cardboard tubes. These tubes were fastened at their farther ends to the crib slats, so that she couldn't scratch herself. Although hating to put her through this, her parents had seen no choice.

The "stiff arms" condition came back a few more times in regressive experiences. Knowing now where we were, we could better fine-tune her further exploration of this state. The affects accompanying it were complex, and it required a lot of attention to sort them out; a story in itself, which I will not go into here. We both came subsequently to feel, however, that our work with this trace of her early past was one of the more important things accomplished in her therapy.

A lot more could be said about this interesting case. But the point I want to underline is the following. I doubt very much we would have ever touched this piece of her past in any other way. Transference phenomena, dreams, and the therapist's countertransference reactions also give hints at times about a patient's earliest years. But those channels have none of the directness, and little of the richness, of the channel of the body; there is no comparison. In certain body regressive states

the preverbal past can be portrayed with a specificity nowhere else to be found. In these instances the body remembers, but not with words; and with few or no images. Paula Heimann (1989) occasionally spoke of "somatic memories," an apt term.¹ I sometimes refer to these motor memories as "kinograms", to emphasize their nonverbal nature.²

To come to a verbal grasp of a kinogram, naturally we face a problem of translation. An elaboration in motor symbolism is not yet an elaboration in words. Often a series of steps must be taken to arrive at a linguistic understanding of the representative state (c.f. chapter 17). And those steps may or may not succeed. Most often they do; and if not one time, then another; such states tending to repeat themselves for a while in the therapy.

There are exceptions, i.e., regressive states which remain persistently opaque. Sometimes the letter is delivered but can't be opened. The example above was almost so. Fortunately these exceptions are a minority.

Of course a major assumption is at play here. It is that body regressive states do in fact symbolize the real past. They reenact selected motor elements of something which, despite possible distortions by phantasy, in some form actually happened. To date, this assumption is backed up only by the soft evidence of clinical experience. There exists no hard scientific research

¹Heimann used the term in a more limited context. She was seeking to grasp how some psychosomatic conditions might reflect the preverbal past (e.g., 1989, p. 141).

²I have partly in mind Aulagnier's (1975) concept of the "pictogram", her name for early preverbal representations. Aulagnier writes excellently, from a psychoanalytic point of view, about the body. But this term strikes me as insufficiently somatic, as too suggestive of the visual.

evidence.³

Two forms of soft evidence are rather persuasive, however. First, in cases such as the one described above, where reliable objective family history is available, collaboration is often stunning. Second, there are, in general, impressive correspondences between (a) the body states and occasional accompanying imagery which patients spontaneously contact and (b) many of the caregiver-infant interactional patterns which have been discovered and described by recent infant development research. This is a fascinating topic which shortly I will take up at some length.

Most of the time when a patient works with his body, what he comes into contact with is not a kinogram. Usually it is a memory in the ordinary sense: something which happened at age

³A situation clearly destined to change. For better or for worse, the minutiae of our lives are today being recorded with a technological thoroughness never before possible. On a social level this is probably a sinister development. But at least as far as psychotherapy goes, we are finally closer to the day when we can seriously research the etiological impact of early family patterns. Family movies and videotapes will provide a source of data. Perhaps too, some of the present-day research videotaping of infant-caregiver dyads. (Child grows up. Comes to therapy as an adult. Study project compares information drawn from the therapy with inferences made from the early videotapes.)

A colleague of mine recently put a group of us through an instructive exercise. A patient who had been in therapy had offered him the use of some old home movies. We watched segments taken from a certain number of these, which showed the patient at age 4 days, one month, three months, and so forth. We tried to observe as exactly as we could the nonverbal interactions between the patient-as-infant and his parents. Our colleague, telling us not a word about the case itself, had given us the task of trying to predict (a) what was likely to have come up during the therapy in body regressive states, and (b) what were likely to have been some of the dominant transference paradigms. Largely we got it right -- and this without microanalysis (a methodology used by infant researchers) of the films and with only an informal group of body psychotherapists. One sees how productive such a direction could be for systematic research.

five years, or nine years, or sixteen years, or even several years ago in his adult life. These are memories which come complete with detailed visual imagery, and usually with an initial verbal grasp of the situation as well.

These memories too -- the ordinary sort -- may have strong body components. In fact it may be the body elements which first appear: a sick feeling in the stomach, a tightening in the legs, whatever. Then the rest of the memory, all the thoughts and the images, trails along afterwards.⁴ Still this is not a kinogram, however powerful the body components.⁵ With kinograms there is not the same verbal dimension, and few or no images. Additionally, to make sense of a kinogram normally we have to look at it as likely reflecting something from the client's earliest years.

Kinograms also emerge less often, in terms of frequency in the therapy. (At least less often in any obvious form.⁶) To make a rough guess, they show up, as an outcome of direct work with the body, perhaps ten to twenty per cent of the time. And even then, only when certain conditions are present.

These necessary conditions seem to be first, that the patient is enough over his or her anxiousness about body phenomena. Otherwise any work with breathing is going to be very brief, a

⁴ Ordinary memories too can once in a while be highly resistant to a linguistic grasp. In that case what stands in the way is anxiety and repression. This has a very different feel from exploring an emerging kinogram, however. C.f the later chapters on work with regression.

⁵Of course there can be intermediate cases not easily classifiable as one type of memory or the other. Nevertheless the general distinction is worth keeping clear.

⁶I suspect that, during work with the body, kinograms actually are present more frequently, but in so muted and fleeting a form they can not be identified and clarified. They may well at times be present "around the edges" of more ordinary memories appearing during a body process, for example. But obviously there is no simple way to verify this.

few minutes and no more. That will not give enough time, and intentionally so (i.e., intentionally on the part of the therapist), to allow a regressive state to develop. Also, the transference relationship must be in a reasonably satisfactory working order. A client whose distrust of the therapist is too strong will unconsciously guard himself or herself, while working with the body, against letting anything from the deeper affective strata emerge.

Another distinction with respect to memories is also helpful. When you work with the body what comes up from the past may be a one-time trauma, or it may be an old interactional pattern.⁷

This distinction is independent of the difference between kinograms and ordinary memories. One-time traumatic events can be encoded either as kinograms or as ordinary memories. It depends upon the child's age when the trauma took place. The same for repetitive interactional patterns. Depending upon the childhood period being represented, it might be a kinogram, or it might be a set of memories complete with images and articulated thoughts which emerges.

Of the two types, the interactional patterns have a greater importance for therapy, by far. Kernberg (1975, 1976) has a good name for their encodings in memory: an "object relations unit." (Or sometimes: a "primitive objects relation unit".) What comes up is a generalized portrayal of one strand of the former rela-

⁷Naturally here too there can exist intermediate cases. One client was sexually abused on (she thought) three separate occasions by an uncle who lived in another country and who visited only rarely. Should we call this a trauma or an object relations pattern?

tionship between the patient and her mother, or between the patient and his grandfather, etc. Portrayed too, at times, can be the relation between patient and some wider family system or subsystem (e.g., the sibling subset, or the mother-father-child oedipal triangle).⁸

These are representations, in other words, of what went on, over and over, between the client and person X. Often this is a kind of transaction which occurred hundreds or thousands of times. Encoded is not only the relational exchange itself, in a behavioral sense, but the typical emotional climate in which it took place as well.

Such representations can show up, directly or indirectly, in dreams, in associations, in work with the body, in the transference, and even (by the mechanism of so-called projective identification, which I discuss elsewhere⁹) in the therapist's countertransference. What a patient must work through, from his or her past, is largely contained in such object relations units.

It would be a mistake, however, to discount the importance of one-time traumatic events. There is no question they leave a trace; working with the body will convince a therapist of that. An accident, a medical operation, a witnessing of a violent death, a rape: the body doesn't forget. This is true of unresolved traumas from any age, adult traumas included.

Sometimes a session in which a traumatic memory emerges is one in which the therapist and the patient have chosen to zero in

⁸Like many object relations therapists Kernberg at times suggests that if a representation is "primitive", i.e., if it belongs to the early past, then it can only portray a dyadic relation. I don't think that hypothesis stands up to clinical reality.

⁹Chapter 23.

upon a certain body part. The therapist might be working with her or his hands, for example, upon some inexplicably tight muscular and connective tissue in the right calf. She or he loosens one layer of tissue, then a deeper layer. Suddenly, out of the blue, the patient *smells* ether. Distinctly, insistently. Or the patient might "feel" something pressing flush into his skin around his nose and mouth. Then he realizes: he is "back there", nine years old, in the hospital where he was taken after breaking his leg, the ether mask against his face. The break, needless to say, was exactly where the therapist was a minute ago unknotting the constricted musculature.¹⁰ There is definite therapeutic work to be done with such memories. Normally it goes quickly. (In a later chapter I will describe in detail on a technical level what is done.) But it should not be ignored.

I must mention too, however, a complication. Often enough it is not so much the trauma itself which is at issue. The seemingly "one-time" nature of such a registered event may be illusory. True enough, the event in question happened only on one occasion. But what made it so intensely traumatic, and what made an inward resolution so difficult afterwards, was some background of interpersonal object relations. Perhaps for the six-year-old child the medical operation was frightening; but worse was awaking alone, in a strange hospital room, and then waiting half the day and most of the next until the first family member

¹⁰Even "body workers" who are not psychotherapists, and who only work physically with the body, will frequently discover their clients confronting such memories. C.f. the account given by Don Johnson in his excellent book (1977, p. 40) on Rolfing, a deep massage methodology: "During his ninth session...I was freeing and separating the distorted ribs on his left side. In the midst of deep sobbing, he recalled that when he was eight years old, he had fallen from a tree onto that side, breaking several ribs; he had been taken to the hospital, and had almost died."

at last took time to visit. The traumatic event may turn out to be only the tip of the iceberg. And the rest of the iceberg has to do with old object relations patterns.

To take another example, a patient working one day with her body, felt "something funny" going on with her eyes. This became a "stinging". Then her throat felt like it was cramping shut, and an aura of panic ensued. Then came a memory of a near-drowning in a swimming pool when she was four. But right along with these intense, terrifying physiological registrations there also arrived the most bitter memories about the object relations context: her not being watched by her mother and father, who were busy socializing nearby, and their belittling of the incident afterwards. This was typical, she felt, of their attitude and responses. Thus the trauma itself, as often is the case, was like an icon of a more general family pattern.¹¹

There exist exceptions, however. Once in a while, during physical work, there comes up a representation of a traumatic event which is relatively independent of the patient's internal object world. Its resolution in therapy can then usually be a more straight-forward affair, and considerably more brief. (How that takes place we will see later).

Which period of the past is the most important? Of course packed into this question is really two questions. One is etiological, causal: which period of his/her past was most formative for the client? The other is clinical: which period is most

¹¹Still another complication is that occasionally a single traumatic memory make evoke, in the same session, a cluster of other traumatic memories, even though there exists little connection among the various past events apart from their emotionally overwhelming nature.

crucial for the therapy to reach? One cannot assume that the answer to one of these questions automatically gives the answer to the other.

Like most object relations therapists I am convinced that the preoedipal past (i.e., the first two lifeyears) is of great importance. Both etiologically and clinically speaking. During this time, for all of us, a certain foundation was created. How we learned with our bodies to let the world disclose its meanings to us began there.

But what about the later periods of childhood? What etiological impact do they have? And how should we view their clinical significance?

About this, object relations thinking divides. There are more or less two camps. This division can be seen most clearly with respect to severely disturbed (for example, borderline or psychotic) clients.

One camp holds that, for such patients, the main problems are to be located in their preoedipal, preverbal history. Something went wrong then; and that is the root of their adult symptomology. This, above all, the therapy must address. (A view which more or less began with Klein (1975) and Winnicott (1958, 1965).¹² For an influential contemporary version the

¹² Melanie Klein (1975), the first to take this line, saw the anxieties and defenses of the "paranoid-schizoid" position (as she eventually came to call it) as chiefly responsible for the symptomology of more disturbed clients. This implied, for her, a series of intrapsychic conflicts taking place during the first several months of infancy.

Winnicott (1958, 1965), who started out in Klein's orbit and then took his distance, kept this emphasis upon the early months. But he shifted from an intrapsychic to an interpersonal point of view. It was not just the internal play of drives and fantasy which created conflict within the infant, he thought; the real environment, i.e., the caregiver or caregivers, were equally or even more responsible. Fairbairn (1953) too, at around the same time, began to think along

reader may be referred to Masterson (1976).¹³)

The other camp sees the contributions of later childhood periods as equally important, or close to it. (Kernberg (1975, 1976) is representative.) The preoedipal time is seen as strongly formative, and as deserving of sustained attention in the therapy. But what comes after in the patient's childhood is considered just as critical. (Or close to it). And just as worthy of therapeutic investigation. I align myself with this latter position.

I can quickly give one reason why. The background to my skepticism about the former position is that I have supervised a good amount of psychiatric treatment, much of it in institutions, with more severely disturbed patients. This acquaintance with many cases and patients has convinced me that, to the extent one can judge, there is plenty more to their etiological picture than just their preoedipal history. Losses, disappointments, violence, sexual abuse, disastrous role models, you name it -- a good number of these patients had it very rough all through childhood, adolescence included. And the pain and terror encountered in later childhood periods has also greatly shaped them, I believe.¹⁴ Certainly when you work with their bodies what comes

similar lines. Guntrip (1982), Little (1982) and others in the object relations tradition then followed suit.

¹³ Masterson for example locates the primary origin of all borderline symptomology in what Mahler called the rapprochement phase (around 18 months).

¹⁴For an excellent discussion of this point see Abend et. al. (1983), one of the few truly searching examinations of basic assumptions about etiology. (It should be added that they also attack Kernberg in this discussion; and that their criticisms of Kernberg are poorly founded, in my opinion. They erroneously saddle Kernberg with an overweighting of preoedipal etiology, a position he has always painstakingly avoided.)

up from the oedipal and still later times has just as tremendous a charge to it as what comes up from the earliest years.

The usual counterargument is that what happened to the patient in his preoedipal history then pre-shaped the rest, so to speak.¹⁵ Because of conflicts and deprivations during his first two years he came to the oedipal period, and to later childhood as well, poorly equipped. So however dramatic his accounts of the later eras, his central problem is still to be located in the preoedipal time. Had his situation then been a more nourishing one, he would have been better prepared to handle whatever occurred afterwards.

I can't agree. There is a certain truth, a useful truth, to the claim of "poorly equipped"; but it is only half the story. The other half has to do with the family environment itself. A family system which is strongly dysfunctional on the level of early emotional nourishment for an infant, is usually dysfunctional in plenty of other areas too. All or most forms of bonding are undermined. Take sexuality, for example. The conflicts, the lack of support, the mixed messages and the double-binds are highly likely to be more severe than is the case in better functioning families. It is not just that the patient as a child, walked into the oedipal period with distorted perceptions, or poor anxiety tolerance. It is also that what she or he had then to face was often overwhelming in its objective nature.¹⁶

Obviously these are thorny issues. My purpose here is to

¹⁵For an influential statement of this point of view see Blank & Blank (1974).

¹⁶Nor could a full causal account stop here. Genetic vulnerabilities, on the one hand, also play a role (c.f. Scheflen 1981, Richters 1987.) As likely do many cultural factors (c.f. Brodo 1993).

clarify what my own perspective is. We are about to enter into a series of chapters in which I will take up in a lot of detail what it means to understand, and to work with, a patient's preoedipal history. It is necessary that we look at this; a therapist can't do good work with the body without having a feel for the intricacies of early development. However, I do not want to give a misleading impression. If I devote more pages to the preverbal period rather than to other childhood periods, it is not that I consider the other ones less significant. I am simply responding to a practical problem: that the preverbal era is more difficult to discuss. A viable conceptual overview, for therapy, of this period requires that one piece together information from different and somewhat heterogeneous sources.

I do very much believe that therapy should reach these earliest strata. There are core elements from our preverbal history which can be brought to life again, and reworked, and resolved differently. Something in us which belongs to this period has a tremendous "self-uprighting" power, as Lichtenberg (1989) and others have remarked.

But to go there requires a certain knowledge and certain skills on the part of the therapist. To begin with, she or he must bring to the encounter with the patient a sufficiently flexible "listening perspective" (Hedges 1983). One must hear the echos of the past even when they are faint. Beyond that, she needs to have in her hands the right therapeutic instruments. This as a minimum will include careful, on-going attention to transference and countertransference¹⁷. Ideally too she will be able to draw upon the resources of the body: perhaps by means of

¹⁷See Downing, *Hidden Currents: Working with Transference and Countertransference*, forthcoming.

a verbal focus on body phenomena, perhaps by means of physical techniques, or perhaps by both.

We are fortunate today in that we can benefit from a wealth of valuable different viewpoints concerning the preverbal past. There are the various modifications of object relations theory, from Winnicott onward. There is the explosion of new data, some of it revolutionary, from infant development research in experimental psychology. And there are the clinical findings of body psychotherapy. What happens if we put together some of the thinking from all three of these areas?

Chapter 9

MOTOR BELIEFS

We are now ready to turn down a different road. I have been going over some of the basics of body-oriented psychotherapy -- what a session is like, how the past comes up, the physical techniques, and so on. I will now take up the topic of infant development. This will set the stage for a more substantial account of why the body deserves a prominent role in therapy.

It will also allow us to confront more directly a related question: which, what "body" are we talking about when we refer to the place of the body in therapy? How, at bottom, should we think about and understand this corporeal reality the patient inhabits?

What I have long found helpful in trying better to understand the body is the thinking of the French philosopher Merleau-Ponty (1962). The question of the nature of the body was Merleau-Ponty's lifelong concern -- unusual for a philosopher. Equally unusual, he brought to this question a rather sophisticated acquaintance with both psychoanalysis and the experimental

psychology of his day.

Merleau-Ponty liked to point out that each of us experiences a kind of double body. On the one hand my body is a thing alongside other things. But on the other, it is that which gives me access to the world of things in the first place. And in this latter role it not merely provides access, like an open window; it also shapes and structures much of the world as I find it.

Think, once again, of a stage upon which a play will be performed. The stage is our perceptual field, the world as we sense and think about and move around in it. Whenever the curtain is up and the play underway, we experience that world as having a particular configuration, like a well designed stage set. Here are these colors, those pieces of furniture, that quality of light: the field is waiting for us to move and act in it. The body, however, is like the designer of the set. It has already organized the field in a thousand ways before objects emerge into our consciousness. This preparatory activity of the body makes possible the very arena in which we sense ourselves as aware and acting beings.

Consider: what kind of stage set have I designed for my play? What kind have you designed for yours? What kind has a patient designed for her/his? I am for approaching these as questions which can, with time and patience, at least in part be answered. One person's perceptual world is organized along lines different from another's, like snowflakes. The body, as a result of its individual history, comes to design the set in its own idiosyncratic manner.¹

¹Genetic and constitutional factors of course must have an influence too. But the findings of infant development research leave little doubt about the shaping effects of the infant's environment, as the next several chapters will make

Of course I further assume that this preparatory or constitutive activity of the body can be changed. And that therapy can help change it, and for the better. This implies too that the therapist and the patient are able, given the right techniques and understanding, together to evaluate what in the body's structuring activity is functioning reasonably well and what not.

Not that such a state of affairs is easy to determine. On the contrary, three formidable barriers lie in the way.

First, it is so easy to presume, wrongly, that how I see the world and how you see it are exactly the same, a point-to-point correspondence. We well know someone else may have ideas different from ours. Yet we often have little feeling for how what Husserl (1970) called the *Lebenswelt*, the experiential life-world, can vary from person to person.² From culture to culture also, to a degree (c.f. Bourdieu 1980); and even from gender to gender (c.f. Irigaray 1985). But as well, literally, from person to person.

Second, each of us tends to take for granted, again wrongly, that the world as I experience it right now is the fixed, the definite, the correct, the only one. We deny the extent to which one's own *Lebenswelt* is just one in a series of potential transformations.

Third, most of this constitutive activity of the body -- the organizing of the stage-setting -- takes place outside our awareness. We have little direct perception of it. Perhaps worse (i.e., worse for the project of therapy), we even lack adequate

evident.

²This fact tends not only to elude us but also, when we are directly faced with it, to make us anxious. A rather common source of countertransference difficulty, especially with severely disturbed patients.

ways to think about it. The nets of our language have been woven to catch other fish.

Those problems are not insurmountable, however. The essential is not to settle ahead of time for a concept of the body which is too narrow.

One quick means of getting yourself more inside this issue is to consider a superb experiment conducted by T.G.R. Bower (1978), a noted general psychology researcher at the University of Texas. Bower's subjects were children aged five to seven.

Watched by one child at a time Bower manipulates a lump of clay. First he shapes the clay into a long thin cylinder. He hands it over, the child inspects it, Bower takes it back. Next he reshapes the same clay into a ball. Then he puts to the child a Piaget-like question: is the ball going to be the same weight as the cylinder, or is one heavier than the other? Usually the child answers immediately that the ball is heavier than the cylinder. Bower then hands the ball over to the child for further inspection.

Plain enough, so far. This is ground long ago plowed by Piaget (1952, 1954). With a series of like experiments Piaget established that until a certain age children fail to understand that the same matter and the same weight are conserved throughout such transformations. The child does not yet possess that schema, that intellectual principle. He must organize his sensory world otherwise, without its help. Or so Piaget thought.

Only there is more to the experiment. Ingeniously, Bower has had a high-speed film taken of the entire transaction. Later review of the film shows, clear as a bell, a little expected fact. Bower is handing the child the ball version -- the second

version -- of the clay. The child reaches out his arm to receive it. Remember, just seconds before the child was stating to Bower his firm conviction that this ball will be heavier than the cylinder. On the film therefore as he grasps the ball we ought to see his arm suddenly rise a fraction of an inch: that is always what occurs when muscles prepared to hold a certain weight receive an object which actually is lighter. But on the film the arm *does not move*. The arms, hands, and shoulders, while forming their muscular preparations, have expected exactly the *same weight as before*.

We are forced to conclude that at this age, in this area, *the child's verbal, intellectual beliefs do not quite coincide with his motor beliefs*. One system is lagging behind the other. Depending upon how we "ask" the child -- whether we elicit his words or his direct body response -- we are going to get two opposed answers from him.

The crucial point, however is not that, in this instance, it happened to be the motor belief system which responded "correctly". What is more important is the discrepancy itself. For the briefest of moments we have been allowed to glimpse a divergence between two distinct modes of appraising the world. Two modes which naturally we would expect to function in harmony but which, interestingly, do not always do so.

Could it happen the other way around? Could the verbal and the motor interpretations diverge, but the verbal be the right one and the motor the wrong one? Certainly. The experience of a phantom limb is a good example. One could cite many examples too from therapy settings.

The possible combinations of truth and error one might even systematize as follows.

Possibility A. The verbal and the motor interpretations converge and are both true. Both are more or less accurate appraisals of the real situation.

Possibility B. The verbal and the motor interpretations diverge. The verbal is false, the motor true. The child in Bower's experiment is in that position.

Possibility C. The verbal and the motor interpretations diverge. The verbal is true, the motor false. An amputee with a phantom limb fits this description.

Possibility D. The verbal and the motor interpretations converge and are both false. Hallucinating an absent person, for example, for seconds I might "believe" both my verbal and motor constructions of the situation. (Were you to ask me at that moment I would tell you he is present. Were you to check my muscular preparations you would find I have activated my body in readiness to welcome him, to flee from him, to defend against him with polite stiffness, etc.)

Of particular relevance for therapy, you will notice, are B, C, and D. All three represent, in different ways, erroneous evaluations of the world. ('World' here includes both poles of the perceptual field, "self" and "what lies outside myself". The error could concern either or both poles. The phantom limb is a false perception of self.) After all, to dismantle some of the illusions which activate our defenses and symptoms is one core

part of what therapy is about.

You will notice too that C and D for that reason present us with a special problem. How in therapy are we to help the patient free himself from persisting false motor interpretations? What our verbal interventions affect most immediately is his linguistic appraisal of reality. But his motor appraisal? That too can be affected by our verbal interventions, but only to a limited degree. The possibilities for change in his motor relationship to reality are incomparably increased if we are able to intervene as well on a direct body level.

A further assumption, needless to say, is that situations C and D apply at times for all of us, and indeed in the areas which matter most to us -- love, work, sex, gender assumptions, etc. Our motor interpretations of the world often reflect a compromise. Adult motor schemas are brought into play, correctly and appropriately; but they are overlaid with abiding motor illusions, with mistaken motor beliefs, left over from our childhood. We could not operate in the world, we could not have a world to operate in, were it not for the background (to use the term of Searle (1983)) of our motor skills. Yet it would probably be a distortion to picture this background as neat and coherent in too strict a sense, like a well laid-out archives. The evidence from therapy suggests rather that portions of the background are an inconsistent, self-contradictory jumble.

Naturally under the right circumstances everything functions smoothly -- for example if we, an adult we, are watching a lump of clay being kneaded from cylinder to ball. In that case the adult recognition schemas, verbal as well as motor, will function without difficulty, and in harmony. Where the story can easily be otherwise, however, is in our encounters (in reality and in

imagination) not with things but with social systems and other persons. Then all kinds of childhood schema may be elicited: belief mini-systems from different developmental periods, competing and sometimes contradictory.

Of course these elicited mini-systems will not be exclusively motor in make-up. A verbal component may be present; may, in some constellations, even be dominant. Generally speaking, the more archaic the mini-system (i.e., the earlier the developmental period from which it is a remnant), the more it will be predominantly motor in nature.

Object relations therapists, for numerous good reasons, like to talk about our "inner and outer representations" of other persons. And of our "inner and outer object world". But by understanding how the body structures our perceptual field we can make this helpful idea more useful still.³

The problem is that to speak of "representations" suggests a kind of picture gallery. One thinks of visual images, imaginatively perceived; or of visual images which are somehow "stored" in such a fashion as to be available for perception. To a certain extent, however, that is misleading. What guides and motivates us are not simply inner photographs of other persons. What animates us are networks of beliefs about other persons. Some of these beliefs must be coded in linguistic form, and others in

³Hedges (1983, 1992) has been one of the few to see the full ramifications of this issue. For example, he nicely shows (Hedges 1992, p. 82) how Edith Jacobson, who was the first to develop the concept of self and object representations (Jacobson 1964), created problems by seeming to restrict the notion of 'representation' to verbal symbolization. Hedges argues that we must widen our notion of 'representation'. It must include not only "the verbal-symbolic mode" but also "the affective, interactive, and self-consolidation modes that characterize preoedipal integrations."

motor form.⁴ Together they constitute an intricate latticework of verbal and motor schemas.

* Our acts of perception -- which really are acts of interpretation -- mobilize this belief latticework. Motor interpretation then unfolds right alongside verbal interpretation. 'Motor' of course has a special sense here: the motor interpretation, and its supporting motor beliefs, are still "mental," still very much "cognitive." We are speaking here about embodiment in the sense of embodied mind.

In fact, that they are cognitive is the whole point. They create a standpoint, they are a standpoint on how the world is. Yet they are cognitions of a special kind. They appraise the world in their own manner; in a motoric, not in a linguistic manner. They do not depend upon the same direct links with language in order to shape our lives. Bordieu has frequently insisted upon a similar point: "Practical belief is not a 'state of mind', still less a kind of arbitrary adherence to a set of institutionalized dogmas and doctrines ('beliefs') , but rather a state of the body" (1980, p. 68). Exactly.

Motor beliefs are the instruments, in other words, whereby the body creates a stage-setting. Every time we walk out onto the floorboards and get on with our play, groupings of motor mini-systems have already done their work. They have already given a form, a partial determination, to the "object world" we

⁴Mark Johnson (1987) in his valuable book *The Body in the Mind* has argued that even many of these verbally coded beliefs depend crucially for their meaning upon more primitive meaning patterns present in bodily experience. The verbal forms of meaning are derived by means of metaphoric extension. What Johnson sees as basic preconceptual meaning patterns seem to me quite similar to what I am here calling motor interpretations. The basic meaning patterns (Johnson calls them "image schemata") create the conditions for the more specific motor interpretations.

will meet there.⁵

To say it a little differently, this manner of looking at the body is not only highly compatible with object relations theory. It even allows us, at important points, to amplify and extend the latter. To take just one example, consider that famous developmental task, self-object differentiation. We may now profitably ask: what, spelled out in detail, are the motor components of differentiation? The motor components of an evolving sense of self? The motor components of an evolving sense of the object? In the chapters which follow, that question will lead us to some concrete conclusions about what is possible in therapeutic treatment.

In a more general sense this point of view merely takes one step farther a line of thinking which has long been a hallmark of object relations theory. Freud's original model was of the psyche as largely a self-contained unit. Internal forces within it oppose each other, creating conflict. Object relations models (there are a number of them but on this point they are similar) instead approach the psyche as essentially relational.⁶ What determines both health and neurotic conflict is a web of relationships, past and present, to other persons.

In a like fashion I am suggesting we regard the body as essentially relational. Naturally it is possible to abstract from its relational nature; and, that abstraction performed, to

⁵C.f. Dreyfus and Wakefield (1988) on "ontological generalization": "the specific pattern already in place in the child's life generalizes and becomes a dimension of the background upon which, from then on, persons and events show up."

⁶Excluding Melanie Klein (1932, 1975), who is best regarded as a precursor rather than a representative proper of object relations theory.

see the body as a self-enclosed box, a kind of monad. You then could go on to describe this monad in whatever terms you wish. You might focus upon its familiar physiological clockwork, for example. Or you might develop a more exotic description which postulates esoteric energy flows and the like.⁷ But either way, apart from acknowledging some minimal "energy exchange" between membrane and environment, you can easily end up underestimating the body's relational nature. You may even end up ignoring it altogether. My preference therefore is for the opposite route: to take as primary, for the practice of therapy, what Merleau-Ponty called the body's intentionality. To take as primary, in other words, that the body is our vehicle to what lies outside us.

I do not mean the therapist should focus upon this dimension alone. There are several other, somewhat independent subgoals which merit attention and which I will discuss too -- for example, expanding the body's ability to relax, improving its ability to handle physiological arousal states, and the like. Granted, were these the only therapeutic aims, then a monad-body point of view would be more than sufficient. I see them as minor, however; or more exactly, as secondary components of a much more central issue. What comes first is the client's relationship, with and through his body, to himself and to the other. This is a standpoint which highlights quite different elements.

How are motor beliefs first formed in earliest childhood?
And how, during the early years and after, do they evolve -- or fail to?

⁷As did Wilhelm Reich. C.f. my critique of Reich in chapter 26.

What can an adult client in therapy find out about her or his underlying motor beliefs? Especially about motor beliefs which may be remnants from the preverbal past?

And how can our motor appraisal of the world change?

Let us turn now to these questions. It is possible today to have some first glimmerings of answers.

Chapter 10

DIFFERENTIATION

An anorectic patient will tell you something extremely curious.

First she (or occasionally he) must trust you. And you must ask the right questions. Then you will hear, as a kind of shared secret, "this arm doesn't really belong to me."

You investigate further. "It belongs to me," she explains, "only up to here," and she indicates a specific point somewhere on her forearm or upper arm. From that point upwards everything "belongs" to her. Downwards, all the way to her fingertips, everything "belongs" to "someone else."

And the other arm? The same. "Up to here": you will be shown another specific point; maybe the same, maybe higher or lower than was the case on the first arm. And the rest of her body? For each leg the identical situation. Up to a certain point on foreleg or thigh the leg belongs to "someone else." Left and right legs both.

Remarkably, one hears this from patient after patient. Not from every last one, but from a high percentage. And always

about all four limbs.

Remarkable too the tone with which it is related. An air of confiding something personal yet banal, a matter-of-fact reality. No hint one could find something startling or curious in these statements. The client might be sharing with you some private detail about how she washes her hair.

Who is the "someone else"? She can't say, this is vague, no idea really. All she knows, and all she is interested in, is that it is "someone" who is not her. Frequently too at this point she will offer a metaphor. "It is as if invisible wires were attached to my body." (Ingrid, age 19, hospitalized in a psychosomatic hospital.) "It is as if I were a marionette with someone else controlling the strings." (Anne, age 20, clinic outpatient.)

What are we to make of this story? A problem with the "body image"? Obviously yes, but that tells us next to nothing. We have to push further.

In the previous chapter I suggested that the world as we experience it is an overlay of two "realities". One is a set of motor representations, motor cognitions, motor beliefs. The other, a set of verbal representations, verbal cognitions, verbal beliefs. Ordinarily in our consciousness we do not pay close attention to what extent one of these "realities" may be diverging from the other. Yet diverge they can, though within limits obviously. And rather easily. And without our bothering to notice. With our words we tell ourselves things are one way while with our motor system we represent the situation another way.

That is what is happening, I am convinced, to a rather extreme degree, with the anorectic patient. As we all do, she

lives simultaneously within these two reality-constructions. And they here and there diverge, as for us all. Only for her the divergence is substantially greater than usual. And it is of a special kind.

I take the statements she makes about "my arm belongs to me up to here," etc., to be a tiny window upon her motoric relation to the world. A symbolic reflection of how she motorically represents "self" and "other". These remarks, brief, flat, yet significant, appear to have little connection with the rest of her discourse. They are verbal, yet they float as if isolated from the larger network of her verbal beliefs.

At the moment she makes these statements she is speaking from the body. Overtly, she is talking about how she experiences her body. Covertly, however, I think she is telling us something more profound. She is revealing the nature of one core set of her motor beliefs. In that particular belief mini-system it is not the case that I exist here, separate, demarcated; and you there, separate, demarcated. Bodies are not represented as discrete, each with its discrete will and agency. Instead bodies are intermingled, are partially fused. Likewise will and agency.¹ "It is as if I were a marionette and someone else were controlling the strings."

If you work with the body of such a patient -- work with breathing, with body processes -- you find out much more about these motor beliefs.² You discover a whole tiny landscape, a

¹More exactly, it is embodied agency, one's most bodily sense of 'I can', which is perceived as inadequately differentiated. I examine this issue more closely in chapter 15.

²Body psychotherapy is an extremely effective means of treating anorexia. My colleague Kerstin Laurén has developed a hospital treatment program which has proven to have a high rate of success for a number of years now. For a good discus-

subworld of motor representations, which has only been hinted at by the cryptic remarks described above. Accompanying these representations will be an emotional terror about the threat of losing the entirety of one's autonomy. Anorectic vomiting, for example, takes on an inexorable logic within those beliefs. A fragile, ever threatened sense of bodily agency, reduced, circumscribed, is imagined to exist only in the most central portions of the body, and there only tenuously. Bringing the food in and out again becomes a mode of magical protection and control over this island of autonomy.

It will come as no surprise if I add that what therapeutic exploration later uncovers is that the "someone else" is the patient's mother. (Is, more exactly, whatever person or persons had the caretaking responsibilities during the patient's earliest childhood years.) The early drama, for a variety of reasons, was (along with some other issues) one of insufficiently achieved self-object differentiation.

Now this idea in itself is familiar ground as far as object relations theory goes. Except that looking at the matter from our present point of view allows us to be somewhat more exact. The patient suffers not only from an underlying lack of self-object differentiation in general. There exists both a motor dimension and a verbal dimension to her differentiation problem. And the possibilities for treatment are vastly enlarged when we distinguish the two.

It would be a mistake, in fact, to see the problem as existing only on the level of the motor representations. What we find, if we explore in detail the vicissitudes of early develop-

sion of this modality as well as outcome and follow-up studies see Laurén (1987).

ment (about which, more in the next chapter), is like a building with a number of floors. Some of the lowest floors consist exclusively of motor representations. But as the floors go higher they are built of motor and verbal representations both. A child first lives out a body-to-body relation with his caretaking person or persons. Eventually language intervenes, however. Thereafter, the two relationships develop side by side: body-to-body, language-to-language.

Often the struggles marking one relationship -- threats to autonomy, unpredictability, emotional distancing, whatever -- are repeated more or less isometrically in the other. But not necessarily; and very often not exactly. Those are particulars which must be uncovered by patient therapeutic work. Ideally ways should be found in the therapy to address both these levels by appropriate technical means.

Apart from questions of technique, however, we must first grasp an adequate beginning idea of what we are dealing with. Here the literature of psychotherapy, object relations literature included, is useful, but it does not take us far enough. One comes across many references to "body image," "body schema," "body ego," and the like. These are useful concepts, and I often turn to them also. Yet they seldom are explicated or explained.³ Worse, they somewhat distort what is perhaps the most essential feature of the child's early relationship to his body. His

³For a truly thorough discussion of the historical development of the "body image" concept see Tiemersma's (1989) *Body Schema and Body Image: An Interdisciplinary and Philosophical Study*. This excellent book also provides one of the best critiques of the concept which I have ever seen. Tiemersma argues that the notions of "body image" and "body schema" when taken by themselves are too thin. They become more coherent when their relation to a subject's wider experiential field is more carefully spelled out.

global experiential unit, so to speak, is less of a body image than a body-body image. What is motorically represented must be, largely, a caretaker-body-plus-child-body intermingled gestalt. We can reasonably assume that only through a long series of developmental steps he achieves -- to the extent he does achieve it -- a motoric representational world of fully demarcated bodies possessing fully demarcated agency.⁴

Joyce McDougal (1980), whose sensitivity to issues about the body is matchless, speaks about the child's gradual transition from a "one-body world" to a "two-body world." That idea comes much closer. It is an intersubjective field which is being organized, not a solo portrait.

I think it is also fair to say that the transition to a "two-body world" is a voyage never fully achieved. Every one of us is still only part of the way along. However, there obviously exist many differences, of kind and of degree. A rough but reliable rule is that the more disturbed the client, the more strongly certain of his motor beliefs will reflect incompleteness of this developmental task. Motorically he will inhabit something more approximating a "one-body world".

Visually such an idea would be absurd -- visually, I mean, in the sense of how we see the world and then report on what we see in words. Everyone past a certain age "knows" that the visually-perceived bodies around him are entities separate from his own body. One rarely finds any ambiguity here, even among psychotic patients in their most florid states.

Yet once we learn to take seriously that our motor relation-

⁴The concept of differentiation is complicated, however. I do not mean to imply that the newborn exists in a totally undifferentiated world. In a coming chapter this issue will be taken up in detail.

ship to reality has its own life, we begin to understand how all this tidy visual distinctness might co-exist with another set of representations entirely. Here in front of me stands someone I know. Visually-verbally, at that level of my "seeing-as", he is distinctly over there and I comfortably and distinctly over here. What I tell myself linguistically (and what if asked I would tell others) is a sensible "distinct selves" account. But in my motor "seeing-as"? At that level my construction of the body-body field might be quite different. There whatever I have achieved of a "two-body world" might at times prove uncertain, fluctuating, problematic. And under special circumstances, considerably so.

But if that is the case, what then might help change the motor organization of my interpersonal field? If something in my early growth was here arrested, or became distorted, is there anything which can alter that situation? How can I bring myself more fully into a two-body world -- and through more than words alone?

Before turning to those questions we need to understand in more detail how the motor intersubjective field in its most primitive forms is first established. What kinds of interactions between an infant and its family bring about a productive evolution? What kinds, on the contrary, structure the field in one or another more pathological form?

Chapter 11

THE FORMATIVE ROLE OF MOVEMENT

Now picture Bernie. Four months old, he sits in his mother's lap. But not with unalloyed pleasure.

Our vantage point is from behind a one-way mirror. We are sitting with Margaret Mahler and her research team. Infants and their mothers are being observed over a longitudinal period of three years (Mahler, Pine & Bergman, 1975). Above all, the subtleties of their bodily interaction are being carefully noted.

Bernie's mother, the team has determined repeatedly, is invasive. She smothers. The boy is now at the height of what Mahler calls the symbiotic period: an intense, highly physical (much back-and-forth touch interaction) stage lasting roughly ages 2 to 5 months. Mother, who cherishes this involvement almost too much, is responsive and generous, but her "holding pattern" is to be all over him like a tent. She is "symbiotically too enveloping" (p. 60).

So how does Bernie cope? He struggles -- bodily. He squirms, he shoves, he maneuvers. We see him push with both his hands against her trunk. This allows him to disengage somewhat,

to "relate to her from a [slightly] greater distance," as well as to "reduce the body surface contact." He can now -- for a brief moment -- look around at her and the surrounding environment. He can breathe, move.

Almost immediately she inches him back in close. He disengages again, shoving this time with both feet while straightening and arching his body, thus creating an even larger intermediary space. And so it goes. For little moments he gets his way; soon after she gets hers.

This behavior on Bernie's part is premature. It is a set of bodily maneuvers which infants ordinarily begin during what Mahler calls the differentiating period, starting around 5 or 6 months. But Bernie has evoked these genetically-stored motor actions earlier, like someone calling for help from spirits in an hour of need. The symbiotic enmeshment is too tight. He has jumped ahead on his developmental track as a partial solution.

We could stay behind Mahler's one-way mirror and watch a good many similar examples.¹ Instead let's step away and reflect. When a child like Bernie grows up what will be the likely nature of his underlying motor beliefs?

Based on work with many adult patients I think an informed prediction is possible. The legacy of repeated interactions of this type will be a motor representational world in which self and other are too much run together. A world in which a differentiated sense of self is tenuous, fluctuating, under siege.

To what degree tenuous? That would depend, we may reasonably speculate, on several factors.

Note for example that the situation for Bernie, though

¹ For example, p. 186ff.

difficult, could, from a bodily point of view, be far worse. (1) He does initiate space-generating movements, even if his repeated experience is that they are largely ineffective. (2) His mother responds to them with renewed smothering but not (so far as we know from Mahler's description) with disturbances of balance support. Nor with angry voice-tones. Nor with brusque, escalating countermovements. Nor with physical withdrawal. (Compare this comment by Horner (1984): "To define the self as separate by coming up against the object can only be sustained if the object remains available emotionally at this point. One can observe the infant pushing away from the mother's body with its feet. How she reacts to this behavior is critical. Does she stay with it, or put him down because he is being 'difficult'?"

(p. 85). Exactly. I would only add that, bodily speaking, there are many more possible variations of unempathic adult response. I base that conclusion both upon work with the "body memories" of adult patients and upon observations of parent-infant interactions in family therapy settings.)

His protest has been sabotaged but not extinguished. I would expect an adult Bernie, working as a patient in therapy, to manifest kinograms (i.e., body memories) in which he finds himself spontaneously beginning a series of boundary-setting movements only to fall into a state of resigned, tense frustration. At those moments he would probably feel a nascent sense of autonomy -- an autonomy vaguely present, vaguely available, greatly desired; which nevertheless he feels he can't fully possess.

In contrast, a certain number of other patients won't (early in the therapy) get half that far. For them, a kinogram-embedded wish for boundaries often will be accompanied by a state experienced as total helplessness. Their surrender if unwilling will

be almost complete. Even the desire itself for something other will be only dimly felt. (Of course through work with the body this will later change in the therapy.)

Probably therefore with respect to the early mother-infant interaction a number of factors must be at play. How massive was the intrusiveness? And how frequent -- i.e., under what circumstances did it take place? Did the mother behave invasively whenever she and the child had close contact? Or did she react that way only, for example, when she happened to be in certain mood states? What too about other caregiving persons (father, a grandparent, etc.)? Did they have much direct contact with the child? How similar or different was their physical interactional style? Finally, what about the innate resources and/or the deficiencies which, genetically speaking, the infant brought to the situation? About that side at present rather little is known. But we can safely assume constitutional disposition must play a role.²

So let us look at our hypothesis as it stands so far. It is that certain physical parent-infant bodily interactions -- for example, some of those described by Mahler -- leave a trace. And secondly, that this trace can be understood as a shaping, an influencing, of the infant's motor representational world. And thirdly, that the vestiges of these early motor beliefs will later affect adult behavior and awareness.

²Well documented is that children differ in their general movement styles already at birth. Studies of movement patterns in the uterus by means of ultrasound even show some consistent differences during the last half of pregnancy (e.g., Gelman et. al. 1982.) Of course it remains an open question to what extent movement styles in the uterus represent an adaptation to a specific environment (i.e., to the mother's body and to external sounds and light) and to what extent they represent genetic anlagen.

Further, the hypothesis here is that the child brings certain wired-in patterns to the situation. These are schemas of movement, like when Bernie pushes his arms outward to create a larger between-the-bodies space. But more than movement alone is involved. In addition to (1) the motor patterns, there is also (2) an affect tone, e.g. here an aggressively-tinged assertiveness, and (3) a series of cognitive appraisals. I will call such a constellation an "affectmotor schema". We must keep in mind, however, that this schema has a cognitive side too.

In part, this is a notion close to that of Piaget (1952, 1954), who maintained that during the first two years the infant's learning is dependent upon a series of progressively emerging "sensori-motor schemas." A schema, he thought, comes to include both the pattern of motor action in which the infant engages (e.g., reaching forward and grasping) and sensory information from the thing itself (e.g., its tactile contours, visual appearance, etc.). The sensori-motor schemas are like an early bodily version of what will later, once intellectual thinking has developed, become concepts and mental images.

However, with the schemas I am talking about the affective component must be equally emphasized. Piaget studied primarily how the infant gains knowledge of inanimate objects. Here we are concerned with the infant's knowledge of humans: other persons, and his own person as connected with them. And especially we are concerned with perceptions and beliefs built up in the context of emotional circumstances -- these being the perceptions and beliefs whose later traces will be so important in a psychotherapy setting. Daniel Stern, a prominent researcher of infant development, in an early book (1977, p. 98) makes essentially the same point.

In considering the internalization of sensori-motor units of experience into mental schemas of objects such as rattles, we had only two elements to deal with: the motor experience of the act and the sensory experience from the object. In an interaction with an alive, active human participant, in which the joint behaviors of the infant and the "object" (caregiver) result in internal changes in the infant's excitation and affect, we have a third element to deal with: the infant's excitatory-affect experience.

In play together are the sensory, the motor, the affective, and the cognitive.³

Another important distinction should be made as well. A reasonable hypothesis is that there exists an innate, wired-in version of the affectmotor schema (c.f. Izard 1977, Tomkins 1962, Ekman & Ellsworth 1972). But this is a minimal version. Once the schema is activated and brought into play it will have a new destiny. It will undergo more development or less development; more refinement or less refinement. It will have a more functional or a less functional evolution (c.f. Frijda 1986, R. Lazarus 1991). An affectmotor schema is innate, but only as a potential. Probably a long process of learning is necessary for it to take its place in the infant's available repertoire.

What is learned, moreover -- to continue this hypothesis -- is not just a refinement of the movement patterns themselves. The ability to utilize and to regulate the affective component

³Mahler makes an almost identical comment: when we think of, for the infant, a general "schema of the developing body and mental self," we must recognize that "the nature of this schema at this age is practical, preverbal, sensorimotor, and sensoriaffective" (McDevitt & Mahler 1986, p. 20).

(with all the physiological subsystems which contribute to affect) is learned also -- poorly or well. (About which more later.) Learned too must be skills of appraisal; and accompanying beliefs. Naturally these beliefs are not coded in language; they are "motor beliefs" (chapter 9).

We must think of these affectmotor schemas as like building blocks. There exist a number of them. Collectively they are what the infant uses to build up his early representations of "self" and "other".⁴ They serve as so many subschemas for the more overarching schemas: "mother", and "father", etc. Or, at a still higher lever of abstraction, for the schema "other person".

We can assume it is a journey with many stages, this evolution of affectmotor schemas. A variety of different movements, of different emotions, and of concrete interactional patterns with the primary caregivers must all play their role. As Stern says, to build up the schema of a rattle is one thing, to build up the schema of "the other" is quite another. And likewise for the schema of self.

Notice that this is a point of view which takes very seriously "real events". I am taking the position -- as does Mahler -- that the shaping of a person's motor representational world is based, in large part, upon what actually happened, in reality, between parent and child. Real events intimately influence the evolution of the infant's affectmotor schemas, and these in turn

*
⁴'Representation' is a term sometimes thought inappropriate for talking about preverbal infants. (Emde, to take just one example, often speaks of the "prerepresentational" self (e.g., 1983).) But this I think amounts to a confusion. Preverbal infants clearly possesses generalized schemas, as well as generalized memories of events (c.f. Stern (1985) for a review of a large amount of experimental evidence for this point.) I mean 'representation' in the sense of a generalized schema, not in the sense of a symbol.

collectively generate his early self and object representations.

That does not imply there is no role for fantasy. Naturally in his perception of the real events the child may have distorted what occurred. Emotions imply appraisal, and appraisals can be erroneous. Especially since we are talking about innate schemas; a schema can be mistakenly triggered, misapplied. We could reasonably suppose that a child at times might exaggerate the "wrongness" of a pattern of interaction; or, as well, that he might add a overlay of fantasy sometime afterwards. In any event this is a question which should remain open. Nevertheless we would expect, at least in most instances, that at the kernel of the fantasy there would still remain, however distorted, some form of objective truth.

This view of course runs counter to the position which Freud adopted. His final position, that is. To a certain extent Freud came to dismiss "real events" as the primary causes of later symptomology and personality development. Melanie Klein (1975) took the same mode of thinking even farther. It is the play of drives within the infant, she supposed, which triggers the fantasies which will later give rise to symptoms -- largely independently of what takes place, objectively, between the infant and his caretakers.⁵ Klein indeed held that the full gamut of these fantasies, a series of sexual ones included, is activated during the first months of the infant's life.

⁵In any case this is the most common and also the most straight-forward way to understand Klein. I think that alternative interpretations are also possible, however. Consider that Isaac, in her influential article (1943) on fantasy, insists that fantasy also *structures the infant's perceptions*. That begins to sound not so distant from what I am here calling an affectmotor schema. Klein assisted Isaac with this article, incidentally, and it was intended as a major statement of the Kleinian position.

It will probably be a long time until there exists, if there ever does, a consensus about this matter in the wider psychoanalytic world. Certainly a shift is underway. At one time only a tiny minority strongly emphasized the interactional real events of infancy: Spitz (1965) and Mahler, for example. Now a much larger wing of psychoanalysts hold this view in one form or another. Some -- two of the best are Dornes (1992) and Lichtenberg (1983, 1989) -- have even tried to integrate many of the new findings of the infant development research. But the debate continues.

In any case, I align myself with those who believe that it is objective interactions, thousands of times repeated, which hone and sculpture the infant's inner self and object world. True, no one is in a position to claim certainty in this area. Informed guesswork is the best that is possible, at least as of today.⁶ All the more reason to base our guesswork upon as wide a range of known facts as possible.

Remember -- it is so easy to forget this -- the infant is still living in the age of giants. He is handled and held and looked at and vocalized to by bodies five or six times larger than his own. How with his own body does he come to build up a complex representation of the bodies of these giant others? And a representation of himself in connection with them -- a body/body field? How does he, as Emde (1983) puts it, "from early infancy on build up progressively more integrated schemas

⁶Obviously someday (two decades from now? more?) we will have the benefit of longitudinal studies far more sophisticated than their present inevitably disappointing form. New advances in means of measurement, in record-keeping, and the like are bound to make this possible. This will be certain to shed much new light upon questions of etiology and causality.

of body self as compared with other selves"?⁷ Now we need to see more data, more examples.

⁷Emde is the researcher responsible for a well-known series of studies of "social referencing", a tendency of infants from nine months onward to check out the caregiver's nonverbal signals before themselves interpreting an ambiguous situation. But Emde is also one of the best commentators upon the development research field as a whole.

Chapter 12

CONNECTEDNESS.

Mahler was not only a shrewd observer; she had an unusual feeling for the body dimension of things. The example drawn from Mahler in the last chapter (infant Bernie pushing against his mother, etc.) was only one of many we could have used. For anyone interested in the relation between therapy and the body her writings are rich with suggestions, aperçus, and vivid observation.

But what about her theories as a whole? How well have they worn? How do they stand up today? A controversial question.

Most object relations psychotherapists, whatever else they disagree about, stand firmly behind Mahler. Her theories are fine, it is assumed. They remain intact, nothing needs to be questioned, one can lean upon them with full security.¹ (Or at

¹Tyson & Tyson(1990) is typical. In the context of a long book summarizing psychoanalytic theories of development the Tysons have nothing but praise for Mahler. They then dismiss the criticisms of Mahler made by Daniel Stern (1985) with a sweep of the hand. Stern's objections, they comment, are based upon a "basic misunderstanding": whereas Stern, and presumably infant researchers in general, observe "interpersonal" interaction, Mahler was trying to speak about "intra-

the most, her idea of an "autistic phase" at birth -- a month-long period during which the infant supposedly can differentiate next to nothing -- must be altered. This in the light of so much recent evidence that babies at birth are capable of many forms of perceptual discrimination (c.f. the next chapter.)

Most general psychology researchers of infant development -- the "baby watchers" -- would hardly agree. The majority of them are flatly disinterested in Mahler.² And among those who do take an interest, that interest is more often than not a negative one. They see her theories as in some parts disproven and in other parts unsubstantiated. In short, as largely obsolete. The most extensive objections of this kind have been made by Daniel Stern (1983, 1985, 1989).

I think a third answer lies closer to the truth. I believe the kernel of Mahler's insights remains both valid and profound. Nevertheless modifications are needed. Once these changes have been made, however, her theory proves to retain a wide explanatory power. Over the next several chapters I will outline the several revisions which seem to me necessary.

At the same time I will point out several problems and inconsistencies in some of the infant development research. The problems arise not from the observations themselves, which are stunning and revolutionary -- indeed these ingenious new experimental paradigms and the data they have produced represent one of

psychic structures" (p. 93, p 95).

This is hardly helpful. It is precisely the legitimacy of our inferences about intrapsychic structure which Stern's careful arguments have brought into question.

²To take just one example, one of the best general surveys of current developmental theory is a book-length overview by Tiffany Field (1990), herself a prominent researcher. Mahler is not even mentioned.

the intellectual adventures of our century. But observations are one thing, theoretical conclusions another. Certain of these conclusions, less than fully warranted by their supporting evidence, merit re-examination. Once this critique has been made, the supposed incompatibility between Mahler's point of view and the new findings is lessened even further.

Let us turn to a first proposal for modifying Mahler's point of view. We need an *expansion of the categories of formative movement*. I will explain.

It is striking to compare Mahler with her psychoanalytic predecessors. What is so original in her approach is her continual attention to the nuances of movement. And, as well, her thesis that certain movement patterns -- together with how the environment responds to them -- play an essential, a formative role in structuring the infant's phenomenological world. This fine insight requires to be extended, however.

Winnicott (1958, 1965) some years before had already taken a major step, by insisting that theories of development must look beyond the simple act of nursing. The entire idiom, to use the wonderful phrase of Christopher Bollas (1987), of early physical handling and interactive exchange must have a powerful formative influence, he thought.

This in itself was a break with tradition. Prior to Winnicott, the period of early infancy either was thought to be of only minor importance. Or, in the case of Klein and her circle, it was held to be important; but only in an intrapsychic

sense, not a real-event sense.³ Or the real events concerning nursing alone were highlighted⁴, as partially determining the outcome of what Freud and Abraham in the twenties had called the "oral phase". By drastically widening his concept of the "holding environment" Winnicott (1958, 1965) opened the door to an entirely new way of looking at issues of etiology.

Winnicott's novel proposal remained vague, however. He had little to say about exactly how and why early handling might have positive or negative consequences.⁵ This remained to be filled in. And Mahler was one of the first to offer to fill in the details, in any systematic sense.⁶

To repeat, Mahler began observing movements. She gave her attention to the physical duet enacted by mother and infant pairs. This led her over the years to focus upon prototypal

³Winnicott also maintained a close professional relationship with Klein for many years. About the role of early infancy real events they quarrelled sharply, however. Or at least most of the time they disagreed. A late-thirties paper by Klein (1970) on weaning is a curious exception. Speaking to a public audience of mothers of infants she counsels them about how to manage the real events of weaning so as to minimize negative psychological impacts. Not only does this contradict her usual theoretical stance (at least insofar as this stance is usually interpreted); she also turned to Winnicott for help putting in together the right advice (Grosskurth 1986).

⁴Or, in the isolated case of Rank (1929), birth alone.

⁵Winnicott had provocative and valuable ideas about the early "holding environment", but his comments are almost entirely about the psychodynamics which he thought were in play. He offers few observations about motoric and behavioral specifics. One sees the contrast, for example, when he discusses his famous concept of the transitional object; here the observations become more concrete (Winnicott 1975).

⁶Another of course was Bowlby, about whom see below. Kestenberg (e.g., 1975) has also made valuable concrete observations of infants' movement patterns. Her more general theories seem of less interest. Sweeping in scope and rather dogmatically stated, they often appear only remotely supported by her specific observations.

movement patterns, the fate and outcome of which seemed to play a central role in determining the infant's habitual interactional style. By inference, these movement exchanges could be said to shape the infant's representations of self and other, she thought.

One could reasonably call this the crux of Mahler's theory. It is her crucial insight. And in my opinion it very much remains valid; in fact, it has been only strengthened by much new data available today.

The best way to expand her theory, however, is to look newly at what should count as a prototypal movement pattern. Which are the exchanges, which are the patterns of the duet, which are so significant that their fate will alter self and object representations? Here an additional basic category seems needed. I will explain.

What Mahler focused upon above all were movements of differentiation. Or in my terminology, affectmotor schemas of differentiation (chapter 10). Let me summarize their progression, as Mahler saw it.

She proposed that infants' attempts at bodily building up a demarcated self-object world begin normally around age 4 or 5 months. In this period, the infant when in physical contact with an adult displays much new behavior. One finds markedly more squirming, twisting, sitting or even standing erect. One finds less molding against the mother's body, less melting, less inactive resting. Even shoving and kicking are now activated; think of Bernie pushing his hands or legs against his mother. All of these are typical movements described by Mahler as defining the "differentiation subphase" (lasting roughly from ages 4 to 7 months). The infant is now "hatching", to use another of her

vivid phrases. A metaphor to note well: for Mahler, during the first four months the infant has been like a chick inside an egg. Now finally the chick breaks through the eggshell: primitive selfness, primitive bodily agency, is coming into play in the self-object field for the first time. "On the baby's side, the space between self and object begins to be created by the baby, in the beginning of the differentiation subphase, when he begins to look around and pushes away from mother's enveloping arms," comments Mahler's colleague Bergman (1980).

Next comes the "practicing subphase" (7 to 16 months). It has its own subdivisions. First emerges paddling; then crawling; then standing; and finally walking and running. What Mahler emphasizes, however, is not locomotion in general, but rather how it is now used to generate a wider circle of space in which the infant can better control the physical distance between himself and mother. The infant expands his sphere of locomotive freedom. His glee and excitement are apparent. Mahler calls this "the greatest step in human individuation" (1975, p. 70).

Finally there emerges the "rapproachment substage" (16 to 21 months). The infant now switches programs, so to speak. He runs away but then runs back; and when back, becomes clinging. He seems to seek reassurance, to need emotional "refueling". The clinging behavior doesn't last long; he "refuels" several minutes, then is off again. But the frequent need for this "rapproachment" with the mother is novel in this stage. And the infant appears to get quite upset if the refueling is not handled in the manner he seems to want.

Note the common denominator. Each stage revolves around some group of movement patterns which set boundaries and/or

create distance.⁷ The exception is the infant's "returning" behavior in the rapprochement stage. But even this returning is followed by a new breaking away: the infant fervently guards his autonomy. It is not that Mahler does not describe other movements and gestures too. She does, as for example the "customs inspection" (infant touches face, glasses, jewelry, etc. of the other) during the differentiation subphase. But she never assigns the same theoretical weight to these other movements. For Mahler it is the saga of the child's growing bodily autonomy which counts.

What is missing in this account? A key element, if one takes seriously her linking of movement and the creation of inner psychological structure. Much data from the new infant development research makes this evident.

The infant in his early psychological growth must not only mobilize schemas of differentiation; he must also bring into play what we might call schemas of connection. This he must learn to do with his body; actively, with initiation, with agency.

All evidence indicates that these connection schemas play an equally essential role in the structuring of his intersubjective field. The infant must construct a representation of the other as reachable, as accessible, as "bridgeable to." He must construct as well an image of himself as capable of doing the bridging.

Consider an example. The new experimental findings are full of them. Here is a fine one from the research of Tronick and his

⁷ Mahler has still another "subphase", which she calls "on the road to object constancy". But her account, much more diffuse, of this period has less theoretical interest.

colleagues.

Tronick is the inventor of the now renowned "still-face" experiment. Its original version (Tronick et al., 1978) worked like this. Videotapes (later to be analyzed in slow motion) were taken of mothers interacting with their 3 month old babies. Following the prior instructions of the experimenter, each mother would approach her infant in her usual fashion. Then, in the middle of a "normal" trading of nonverbal signals, the mother would suddenly make her face go immobile and would freeze all her body movements. The infants reacted as though stunned. They appeared highly upset. They made movements and expressions of obvious protest, then usually withdrew by turning away or looking down.

The original still-face experiment is in itself fascinating enough. It demonstrates how, from early on, infants in their interactions with caregivers show a clear desire for certain intrinsic parameters or "rules" (Brazelton et. al. 1974). These rules (in their particulars a little different for each infant) concern the rhythm, the level of stimulation, and the degree of reciprocity of the exchange. They govern interactions of mutual gazing, of touch and body movement, and of vocalizing, as well as exchanges in which these different "channels" (Stern 1985) are variously combined. The still-face experiment shows in a dramatic fashion the strength of the infant's expectations that an interaction will proceed along certain lines. A major "derailment" produces immediate anxiety and concern.

But it is another, later study undertaken by Tronick I would like now to describe in greater detail. The "still-face" experiment was repeated with a number of mother and (6 month old) infant pairs. This time, however, a series of videotape analyses

were also made of the normal, habitual interactional patterns of each pair. Then the nuances of each infant's response to the still-face situation were compared with the typical back-and-forth exchanges between the same infant and his mother (Tronick, Cohn and Shea, 1986).

The mother-infant dyads, moreover, were sorted into two groups. One was made up of pairs whose habitual motoric exchanges displayed obvious positive qualities (determined according to precise criteria). The mother typically was quite sensitive to the infant's rhythm, optimal stimulation zone, and the like. These pairs in this group had built up a certain mutual interactional competence.

The other group consisted of dyads whose normal nonverbal exchanges were characterized by either marked overcontrolling or undercontrolling from the side of the mother. The mother, in other words, tended either to override the infant's signals or to undermatch them. Thus their typical interactions were (measurably, quantitatively) far more "nonreciprocal."

The interest of the experiment was to evaluate any observable differences between how the infants from the two groups responded to the mothers' unexpected still-face behavior.

The results were clear. And dramatic.

The infants from those pairs which in their habitual exchanges had displayed a high reciprocal competence went through a typical sequence of reactions. When the mother went still-face they would first turn away, breaking eye contact and twisting their bodies. But that would last only several seconds. Then they would turn back and become highly active. They would move and vocalize while looking directly at the mother's face; their behavior now became an obvious attempt to re-engage her, an

attempt to elicit some response other than this disturbing immobility. Only after repeated attempts to re-mobilize the mother would they give up, and, breaking contact again, lapse into some more passive posture.

The infants of the other group -- the one having a low reciprocal competence -- showed a markedly different behavioral sequence. At first they reacted, as did those of the first group, with turning away and similar distressed behavior. But, even though upset and agitated, they initiated nothing further. They rarely turned back and tried to re-engage. They made few attempts to elicit some other response on the part of the mother. The broken connection they simply allowed to stay broken.

* That eloquent data speaks for itself. One set of infants had already built up a certain motor mode of being in the world. In this mode the other is perceived as approachable, as contactable. And the self, as capable of engaging, of animating, of throwing out a nonverbal bridge to the other. Tronick justifiably hypothesizes a primitive sense of "effectance." This infant has learned that the actions of his body have an effect upon the other. He also possesses an available repertoire of motor schemas which structure his intersubjective field accordingly.⁸

The other group of infants, however, are already living in a differently structured intersubjective field. They are operating with different dispositions and different expectations. For them a sense of the availability of the nonverbal bridge is weaker.

⁸Worth adding is that an additional study (Tronick et. al. 1986) of the same infants when they had reached one year of age further confirms that we are here dealing with an enduring inner condition. Judged by a series of measures, those infants who had responded to the still-face situation by actively trying to re-engage the mother were rated as substantially more secure in their general attachment. Those who had failed to try to re-engage, as substantially less secure.

The motor connectedness to the other is far less developed. Tronick speculates about their underlying attitude of "helplessness" with respect to producing an effect upon the other. That seems right: helplessness as a blank, learned helplessness⁹, just where a sense of bodily agency should be. And corresponding to this blank, a now habitual representation of the other as relatively unreachable, relatively unmodifiable, relatively inaccessible.

One must underline too how thoroughly both this "effectance" and this "helplessness" are a bodily affair. We are speaking about the body as a whole here. Infant researchers, referring to the interactive sequences so much studied in today's laboratories, often refer to "mutual gazing". But this term, though accurate enough, is too thin. It doesn't begin to convey the extent to which the rest of the body is involved.

The infant, for example, must orient himself towards the caretaker by positioning his body as a whole. And as the interactive chain progresses he responds rhythmically with full body movement -- rhythmic actions which, let us remember, provide essential timing cues for the adult partner. Even the smile which typically comes at peaks of excitation is poorly described as -- just -- a smile. It is a smile unfolding along with a small flurry of limb and torso shakings and bouncings. (Read any of the more detailed accounts in the research literature. Or watch your own small children.)

Interestingly, the adult also tends to bring the full body into play. Amplified postural shifts and gestures, themselves a

⁹Seligman's (1975) concept of learned helplessness is most relevant here. I will say more about this in a later chapter on work with regressive states.

bit "baby-like" in nature, both reflect and anticipate the infant's movements. These provide what Tronick and others call "continuates": a set of markers making it easier for the baby to continue his own chain of responses (e.g., Tronick et. al. 1979, Stern 1977.).

Of course any adult-to-adult conversation will also have its own accompanying stream of nonverbal punctuation. But the non-verbal counterpoint which an adult spontaneously brings into play with an infant is different. It is slower, and more exaggerated, almost to the point of caricature. And it is far more rhythmic.¹⁰ Unconsciously, instinctively, the adult comprehends that the infant must learn the steps of the dance. Our role as educators is apparently wired-in too.

That does not mean, however, that we necessarily are benevolent educators. The caregiver is a kind of sculptor. Typically he/she assists certain affectmotor schemas to emerge with great finesse, while leaving others in a state of relative underdevelopment. This is not a reflective process, of course; both the adult's plan, so to speak, and also its implementation lie almost entirely out of awareness. The parent shapes an infant's affectmotor schema repertoire, but he does so largely unconsciously, and for largely unconscious purposes. This is an essential point to which I will later return.

More important at the moment is another issue: the nature of the affectmotor schemas themselves. The example from Tronick, I think, makes clear -- and current developmental research is full

¹⁰ M. Bateson (1979) makes a cute but pertinent observation: "I was fascinated after the birth of my daughter in 1969 to find that for about 36 hours after birth, if I was not holding my daughter but could see or hear her, I was likely to start tapping and jiggling anything I held, a book, or my own knee."

of such examples -- that it is not only the schemas of differentiation which are of lasting significance for embodied agency. The infant's ability to impinge upon the other must equally be unfolded. He must build up a motoric representation of the other as engagable, and of himself as able to engage. Diverse connection schemas will activate various different combinations of body parts. When initiating a "mutual gazing" interaction the infant will especially use certain movements of the torso, neck, and eyes, as was evident in the Tronick study. That is only one connection schema, or rather one small grouping of them. There are others, as we will see.¹¹

It seems to me fair to say that this revision mainly adds to Mahler's framework, rather than contradict it. I am staying with Mahler's insight that bodily interaction during the preverbal period plays an essential structuring role. What must be expanded is our picture of how this drama unfolds.

Mahler saw only one side, the saga of separation and differentiation. But there are two sagas to be explained, two parallel stories, and the second is the saga of connectedness. One would

¹¹ What I am calling the "connection" schemas could also be referred to as "bonding" or "attachment". I have avoided those terms, however, as they are so evocative of the theories of Bowlby (1960, 1969, 1980). True, in one sense you could say that Bowlby studied connectedness just as Mahler did differentiation. True too, what Bowlby called "instinctive response systems" -- following the mother, clinging, etc. -- certainly amount to affectmotor schemas, or groupings of them.

But some differences are important. First, Bowlby was concerned mainly with how the infant acquires "proximity", and not so much with what happens once proximity is achieved. About close-quarters rhythmic interactional exchange, though aware of it (1960, p. 199, p. 203), he has next to nothing to say. It simply was not what he chose to study. Second, he usually describes his "response systems" as "fixed": meaning, once they are elicited they are simply there. Either they are switched off or switched on. Little is said about subtle variations in their evolution. (C.f. Spitz's (1960) critique of Bowlby.)

think from reading Mahler on the "symbiotic phase" (1 to 4 months, i.e. this is the forerunner, in her timetable, to the differentiation saga) that connection just happens by itself. The mother is active and does the effort, the infant just passively receives. But that doesn't fit the facts as we now know them, thanks to a flood of new data. The capacity to make bridges to the other is equally, for the infant, the product of a long gradual journey. And this second journey too has its crucial twists and turning.¹²

I might add that this point of view not only fits better with what we now know about infant development. It is also confirmed, if indirectly, by much clinical evidence in body psychotherapy. Adult patients who explore body regressive states often come into contact with the following constellation: (a) a "body memory" of what appears to be an early conflictual situation, (b) a wish to use or find a specific affectmotor schema, (c) a sense that the schema is unavailable, in part or in full. Often enough the unavailable or overly restricted schema is a differentiation schema. But just as often it is a connection schema. Both kinds are encountered frequently; and both kinds, if the relevant schemas are newly to evolve, seem to require

¹²C.f. Pipp: "The focus upon separation -- to the exclusion of an equal role for processes of connection -- unnecessarily restricts an account of the development of how infants relate senses of self, others, and relationships" (1990, p. 243). Exactly. And Emde: "[we must] postulate that in early self development, processes of autonomy are concurrent with processes of connectedness" (1990), p. 35). C.f. also Müller-Braunschweig's insistence upon both *Bindung* (connection) and *Trennung* (separation) as major organizing categories for building up a coherent overview of infant development research. Though based upon research from the early 70's and earlier, Müller-Braunschweig's excellent book remains a model of how to approach the affinities and the seeming contradictions between psychoanalytic theory and infant development research.

sustained and systematic therapeutic work.¹³

But I am jumping ahead. Before I pass to issues about treatment there is more to be said about these schemas themselves. We need to see more examples, and to get more of a picture of how these two intertwined dramas, that of differentiation and that of connectedness, together build up the motor intersubjective field.

¹³Searles (1979) once wrote a review of Edith Jacobson's *The Self and Object World*. In this one-sided but brilliant critique he points out how Jacobson's overemphasis upon autonomy and differentiation leaves out important sectors of human relatedness. Much the same could be said of Mahler, who was close to Jacobson and who adopted practically wholesale the latter's framework. Mahler's autobiography (1988), with its account of her own family background, makes clear some of the personal reasons for such a bias.

Chapter 13

VICISSITUDES OF GAZE AND TOUCH

In the last chapter I explained the difference between two types of affectmotor schema. The infant must develop both connection and differentiation schemas. At issue is the eventual richness or poverty of his self and object world. Let us turn now to some more implications of this perspective.

A special problem concerns how we understand the timing and progression of infant development. Mahler here had some definite ideas.

According to Mahler, differentiation begins only at age 4 to 5 months. What comes before, first, is a short (age 0 to 1 month) "normal autistic" period. The infant has only diffuse, unfocused perceptions during those earliest weeks, she thought. And next, a period of "symbiosis" (age 1 to 4 months). Here there takes place a kind of intensive exchange with more awareness and alertness on the infant's side. This symbiotic period, as she describes it, is the closest of her notions to what I have been calling connectedness. (In her account there is nothing

about the critical element of agency and reciprocal activity on the infant's part, however.¹⁾

In the light of what is known today, another revision of Mahler's perspective is here necessary. This proposed sequence must be rethought. There is little question. The experimental data is massive.

What recent research makes evident is that *rudimentary forms of both types of affectmotor schema are operative at birth*. There is not, as Mahler thought, first a period of connectedness (in her more limited sense) which is then followed by a period of differentiation. Instead both formative adventures start at birth (if not before). Both evolve together over the succeeding months, with new schemas progressively coming into play. They are not two stages of a journey; they are two parallel roads.

To see this, it is easiest to start with "mutual gazing" reciprocal behavior. We already encountered in the last chapter the importance of reciprocity. Infants "expect" that they can contribute to the nonverbal exchange from their side. Of course Tronick, in the "still-face" experiments, was observing infants of 3 months or slightly older. But many studies have shown that a basically reciprocal nonverbal flow between infant and caregiver is already present in the first several days of life (e.g., Brazelton & Cramer 1990).

What this data forces us to acknowledge is a new appreciation of the infant's body at birth. Surprisingly, this tiny body

¹On the contrary, during the symbiotic phase the infant's experience is said to be one of "fusion" with the other. Sometimes Mahler ascribes this to the infant's lack of perceptual capacities; sometimes she suggests it is an "illusion" which serves a protective function. Either way there is little room in her concept for a budding sense of agency.

is already quite well equipped, physically and motorically, for interactional reciprocity. Granted, compared to their caregivers, neonates (i.e., recently born infants) have far fewer motor actions available. But as it turns out they have quite enough. The muscle groups which direct eye movements and head turning are already functioning quite well at birth. Putting these operative muscle groups at once to work, the infant from the beginning takes over his share of the interactional exchange -- or tries to.

This could have never been proved without the use of videotape and film. What that new window reveals is a back-and-forth play of nonverbal signals between infant and caretaker. Too rapid (often faster than one per second) for the naked eye, many of these signals can be delineated and quantified only through later microanalysis. (A film can be studied frame-by-frame, or a videotape in slow motion.)

What such microanalysis reveals is an astounding mutuality, a two-way ping-pong flow, in the interactional exchange. One discovers that the infant is as likely as the adult to be the one to initiate eye contact, for example. He is also as likely to be
 * the one to break it off. Moreover he gives evident body signals, a kind of nonverbal metamessage, whenever he wants the sequence to stop; or when he wishes a shift in rhythm; or when he needs a momentary pause. Frowning, twisting, stiffening, turning or lowering his head or sliding away his eyes are typical indicators (Brazelton & Cramer 1990).

Note too how *both* connection and differentiation schemas are here already at work. In limited forms, of course. The infant turns his head or his eye, seeking contact: connection. He shifts his eyes away, wanting a break in the contact: differenti-

ation. His muscular equipment is minimal. But what he has he uses actively, bringing both connection and differentiation into play.

What then is the difference a new-born and a 5 month old infant like Bernie of the previous chapter? Basically it is the amount of muscular apparatus each can use, and the modes of bodily exchange thereby made possible. Otherwise the dynamics are similar. A 5 month old Bernie can push, shove with his feet, sit erect, twist the full length of his spine. A 3 day old infant can do only miniature versions of such evasions; as well as miniature versions of contact-establishing, and contact-maintenance, movements. But within this tiny circle of useable actions he will try to implement some of the same aims as later with the larger circle.

Of course he may have more or less success. This is another of the critical findings of the new research. For example, just as Bernie's mother invaded and smothered his distance-setting movements, so the adult with a baby several days old may effectively mismatch the latter's rhythmic signals. The adult may overcontrol, analogous to Bernie's mother. Or undercontrol. Or -- worst outcome -- thoroughly miss the signals as a whole, giving no matching help whatsoever to the interactional dance.

In other words, not only are both types of affectmotor schema, connection and differentiation, operative at once after birth. In addition, both types are being sculpted and shaped, unconsciously, by the caregivers. The stamp of culture upon the body starts at day one.

Obviously this must have consequences. Some have been well documented.

One finds them first on a micro-level, so to speak. When an

interactional rhythmic exchange is "derailed", the infant reacts with immediate aversion signals. Brazelton (Brazelton et al. 1974), for example, found that whenever mothers failed to include enough pauses in their nonverbal engagement, the infants, unable to reciprocate with their own signals, tended to break off the interactional sequence entirely. More extreme situations, such as grossly intrusive overstimulation, were likely to produce a more escalated distress response on the part of the infant -- crying, flailing, etc.

One also finds a next level of information concerning more global disturbances during the first several months. The infant reacts not only in the moment; he develops more lasting responses and habituations as well. Brazelton and Cramer (1990) have documented strong correlations between, on the one hand, grave eating and sleep problems during early infancy, and on the other, consistent patterns of derailment of nonverbal interactional sequences with the primary caretakers. This is a finding of no minor significance; during the earliest weeks, disturbances of eating and sleep patterns are the primary indications of distress in an infant.

Equally sobering is that Stern (1971), Tronick (Tronick et al. 1986) and others have shown that consistent dysfunctional rhythmic exchange during the early months predicts lack of secure attachment at age one year and even later. A number of other studies in turn have shown that the degree of secure attachment at age one year (for how this is measured, see the discussion below of the "Strange Situation" experiment) predicts a series of attributes having to do with both learning abilities and social adjustment at ages three to six years. (See Sroufe (1989), Sroufe & Fleeson (1986) and Greenspan & Lieberman (1988) for good

summaries.)

A mounting body of evidence thus forces us to this conclusion: the nuances of the nonverbal exchange have a decisive impact from day one onwards. There is a constant negotiation between the tiny body and the giant body. A consistently dysfunctional outcome will leave lasting traces in its wake.

From this point view Mahler's underlying intuition -- that movement interplay has formative power -- looks more valuable than ever. Its application is even broader than she first claimed. Two major revisions are necessary, however: a reworking of Mahler's timetable, and a widening of her hypothesis about which movements have formative power.

Now consider a related question.

Thanks to the infant development research of the last two decades we have access for the first time in history to some of the realities of the pre-speech infant's world. There exists nevertheless a bias in the new research. A slant, a special perspective which, if we are not alert to it, can easily mislead.

This is the natural result of the very technology which has made the new research possible. What especially has opened the window upon the infant's preverbal world? Film, with the chance to study it frame by frame. Videotape, with the chance to watch it in slow motion. I don't mean to discount the creativity of much experimental design. But the unique vantage point given by slowed-down visual analysis is hardly to be underestimated.

Yet it is visual, this new vantage point; purely, relentlessly. Only what can be watched from outside, only what the cameras can register, will be taken into account.

And what is eliminated thereby? Most of the universe of touch.

The cameras can show us in a rough fashion how the infant is being held. They can let us read how certain of his larger movements "reply" to the holding. We can follow the timing of postural changes of both infant and caretaker, we can trace how these changes match gaze behavior, vocalizing, and the like. Yet lost to the cameras is all the more subtle ongoing interplay between toucher and touched -- arguably a major sector, if not the most major sector, of the infant's earliest interpersonal world. Mutual gazing behavior clearly is of tremendous importance; the evidence is in on that. But would anyone want to deny that direct body contact likely is also shaping the infant's experience?

What can we do about this lost dimension?

Obviously first, acknowledge that it is missing. Surely someday, with the aid of still more refined technology and means of measurement, these so elusive factors will come more into focus. But until then, we should be aware of how thoroughly they have slipped past the nets of contemporary theories.

Second, we can be attentive to what little is known so far, empirically, about the touch universe; and attempt to extrapolate from there. I will go into one helpful example at length.

In the seventies's a classic study was conducted by Ainsworth (Ainsworth et. al. 1978) and a team of colleagues. A point of reference for much later research, it has since been greatly cited, frequently imitated, and its results many times confirmed.

I would like, however, to take up an aspect which has received relatively little comment. One advantage of Ainsworth's

study is that it generated an unusually large amount of observational data. And if we look at this data more closely we come across some highly interesting information about the role of physical touch.

Working in the tradition of Bowlby, Ainsworth studied the interactional patterns of a group of mother and infant dyads. These patterns were observed repeatedly over the course of the infants' entire first year. Observer teams went into the families' homes in order to have the opportunity to watch interactional exchanges under many different daily life circumstances.

At the end of the year Ainsworth used a sophisticated experimental design -- the "Strange Situation," a research instrument much imitated ever since -- to measure the degree of security each infant seemed to display in his/her attachment to and contact with the mother. This test was conducted in a laboratory where the observational context could be more tightly controlled.

Discussions of Ainsworth's research usually focus upon the "Strange Situation" itself -- what she and her team reported, how they quantified what the cameras showed, etc. However, what is of importance for us here is a rather different point. I will therefore only summarize the "Strange Situation" itself. Mother and infant are alone before the cameras. Enters the "stranger," a third woman unknown to infant. Infant's stress reactions are noted. Next, mother leaves the room, returns after three minutes. Infant's "reunion behavior" is noted. Then once again mother goes out for three minutes, comes back. The new round of "reunion behavior" is noted. (The reader wishing more details may be referred to Sroufe & Fleeson (1986) and Greenspan &

Lieberman (1988), who not only describe the design but also provide good reviews of the now rather extensive literature on subsequent "Strange Situation" studies.)

Instead I would like to turn back to what Ainsworth and her colleagues saw in the families' homes themselves. What we discover in their reports is that over the course of the year the research observers paid an extremely high degree of attention to touch and physical contact.

For example, they watched with care how much the babies were picked up; with what manner and style they were picked up; how, when holding, the mother positioned her own body; the extent and location of body-against-body contact; and the degree to which the mother seemed to take account of changes of position in the infant's body. Rating scales were used for each factor. More generalized descriptions of contact styles were included too. One mother was described for example as "holding the infant at some distance, with arms stiff and straight in front of her, as though the infant is being transported on a platter."² Some mothers routinely brought their infants against their chests while others tended wherever possible to avoid even that much contact.

* They noted as well many details concerning the corresponding behavior of the infant. For example, the frequency of spontaneous motor approaches to the mother; the degree of full-body reaching for contact, vs. "tentative" reaching for contact

²The quote is from Main (1990), who later undertook extensive further analysis of Ainsworth's raw data. Incidentally Main is, of all the researchers who have continued building studies around the "Strange Situation," by far the most sensitive to the subtleties of close-quarters physical interaction. Her own accounts (e.g., 1990) are a model of exactly what we need more of.

through the hands or fingers only; the extent and frequency of "sinking in" (relaxing the body, letting it comfortably shape itself to the mother's body); and the extent and frequency of stiffening, squirming, pushing away, and the like.

Finally they evaluated the degree of reciprocity, or lack of it.³ An assessment was made not only of the mother's general style of touching, but also of her ability to co-ordinate her touching with the infant's signals -- two quite different dimensions.

Now about the results. If we look carefully at Ainsworth's account we discover some very pertinent information.

A first result alone is of great interest. Ainsworth's team coded many aspects of maternal care, not just body factors. They then posed this question: which aspects would prove most significant when it came to correlating the mothers' habitual, everyday actions with the later results of the "Strange Situation" test? In other words, which everyday behaviors would stand out as having strong statistical links with "secure attachment/insecure attachment" evaluations made later in the laboratory? What proved most significant was precisely those elements I have just * described: "interaction in the context of close bodily contact" (p. 153; c.f. p. 125, p. 292).

A second result. The tested dyads were broken down into separate groups. Those infants who, at age one year, gave evidence (measured by Ainsworth's criteria⁴) of strongly secure attachment, proved, as a group, to be the ones whose mothers had

³Only through direct observation, however. Not by means of film or videotape.

⁴According, in other words, to their reactions in the Strange Situation.

been independently scored as the most capable in the domain of touch and physical contact. Those infants demonstrating weaker and/or more conflicted attachment behavior turned out to belong to the dyads where touch transactions were visibly less functional.⁵

Finally, perhaps the most striking finding of all. It is that the amount of touching received was not very relevant.

"Deprivation" or its opposite had little effect. What was critical was the quality. Timing, responsiveness and general interactional bodily competency proved to be the central factors.⁶ Included here is -- this cannot be too strongly emphasized -- the room, or lack of it, for the infant's own touch initiatives. Ainsworth poignantly describes how some infants are regularly held, stroked, rocked and carried in sufficient or even more than sufficient amounts -- yet they systematically "learn" that their own attempts to initiate or to redirect a physical

⁵These are Ainsworth's A and C groups. The A group was designated "insecure-avoidant": in the Strange Situation the infants refused contact with the mother at the moment of reunion. The C group was designated "insecure-resistant": the infants sought contact, but in an angry, distressed, unsoothable way.

⁶Obviously we can assume, however, that extremes of deprivation were not studied. Here is another way that the nature of the experimental "window" (in this case, observers in the home) preshapes the results. A mother who might otherwise have veered towards more extreme neglect of an infant, clearly will suppress that tendency if for a year she has scientific visitors in front of her. The same for violent and abusive behavior. Most likely the visitors never would have been invited in the first place.

For hypotheses about the extremes of deprivation, studies such as the work of Spitz (1965) and Bowlby (1980) with hospitalized infants are more to the point. A small amount of research (e.g., Cicchetti et. al. 1990) has also been conducted with infants who have been battered.

contact sequence are doomed to failure.⁷

Notice how much the picture we here see taking shape differs from many of the assumptions made about infancy in our theories of psychotherapy.

Consider what has traditionally been called "oral deprivation." You might think of this as a lack of mouth-to-breast contact. Or, as has been more the tendency over the years, you might mean it to include bodily contact and holding in general. But the basic hypothesis has been the same: the most likely dimension which has caused the child early pain is that of too little vs. too much. The factor of quantity, in a word.

If Ainsworth's observations are valid, however, quantity has (barring extreme situations) little to do with it. The key to the mystery lies somewhere else entirely. Quality is what we should be thinking about -- and, moreover, what we mean by "quality" can be defined further. Early touch contact, no less than early mutual gazing, is an exchange requiring shared rhythms, shared maneuvers, reciprocity. There must be a flow of signals where both sides contribute and both sides respond. The idea of a passive infant simply soaking up greater or lesser amounts of touching/nourishing/soothing/etc., is a notion we are going to have to put aside. The true situation is quite a bit more complex. Above all, it appears that even in this obscure but critical domain of touch we are forced to think about a nascent sense

⁷Highly significant, by the way, is that it was exactly this factor which was common to both groups demonstrating less secure attachment: Group A ("insecure-avoidant") and Group C ("insecure-resistant"). In general these two groups had little in common with respect to the observed dyadic exchanges at home. The major trait they were found to share, however, was the mother's "mistiming" and "lack of sensitivity to the baby's signals" (p. 315. c.f. p. 237, p. 300).

of bodily agency.

Daniel Stern (1985) tells an instructive story. He and his colleagues were asked to consult on a case at a local psychiatric hospital. A puzzle had manifested itself, and no one could figure it out.

Nor at first could Stern and his colleagues. A twenty-nine-year-old psychotic woman had been hospitalized along with her 10 month old daughter. The puzzle concerned their relationship. The woman appeared to be highly attentive to her daughter's needs, and, surprisingly, to be sensitive and capable in the area of physical contact. Nevertheless something about the whole thing deeply bothered the hospital staff. They felt that something was drastically wrong, yet they couldn't specify what.

At first Stern and his colleagues simply watched the two of them. That yielded few clues. The woman seemed obviously concerned about her daughter. She made "sure that no harm befell her, tried to anticipate all her needs," etc. Included in this parenting activity was a conscious attention to the finer nuances of body contact. For example,

the mother gently took her sleeping baby and began to lay her on the bed so she would stay asleep. After she had ever-so-slowly eased the baby's head onto the bed, she took one of the baby's arms, which was awkwardly positioned, and with her two hands carefully guided it to a feather-like landing on the bed....

So what was wrong?

It required videotaping to find out. Tapes were made, an analysis was done -- for Stern and his team, their usual research procedure.

What showed up was that the mother's contact was totally

oblivious to the infant's nonverbal input into their interactions.

Of all the mothers we had ever observed, this mother was the least attuned. In the course of two observations on different days, she performed no behaviors that met our criteria for affect attunement. (They usually occur once a minute, using strict criteria.)

In other words, here was an infant who was touched often and touched well, yet who was living in a state of deprivation of great seriousness -- a deprivation of something which should be present at the heart of early physical contact. Her own potential agency was being shunted aside and given no room to grow. There was no chance for her to acquire "effectance"; as Stern remarks, the one path open to her was to become supremely passive and compliant. She was being given the role of audience for a kind of exquisite kinesthetic performance. Whereas her, and any baby's, most urgent need is for a touch duet.

To sum up, the evidence from the study of mutual gazing behavior alone is enough to leave no doubt that Mahler's timetable must be altered. In the reciprocity of mutual gazing we already find affectmotor schemas of both general types, connection and differentiation, well at play. From birth onwards an infant will be given more or less room to develop these schemas. That will have a radical effect, we now have reason to believe, on his earliest sense of bodily agency and bodily autonomy.

This hypothesis becomes even stronger when we turn to the area of early physical contact and touching. Unfortunately, present-day research methods have almost no access to that arguably crucial domain. Some solid empirical observations have been

made nevertheless. And if we interrogate these observations rather closely, they imply conclusions very like those suggested by the research data on mutual gazing. On the level of physical contact itself the infant seems to have an equivalent need to develop schemas of both connectedness and differentiation.

This impels us to rethink some of our most traditional ideas about early infancy. We need a concept of physical contact as a domain requiring learning and competence. From day one the infant is acquiring skills; acquiring them well or poorly. These must include skills of touch and of negotiating body contact. They must include the building up of a capacity of giving oneself, bodily, over to feeding; to states of alert, activated touch exchange; to repose; to being calmed; to sleep. Here are acts which are totally "natural". Yet they are the site of a tremendous first initiation into agency, autonomy, and the power to benefit from relation with another.

I should add that an indirect confirmation of the formative influence of these early physical contact transactions, comes from the clinical evidence of body-oriented psychotherapy. Needless to say, once again this means only an extrapolating backwards from what occurs in the therapy of adults. But what comes up there, when one works with the body, makes an impression: strong fears, wishes, and underdeveloped affectmotor schemas having to do with body contact.

Sexual anxieties and longings of course also make a contribution here. But much of what emerges about contact and touch has more the flavor of the preoedipal, the preverbal, the presexual. We are speaking about an elusive but, I suspect, fundamental dimension. Our deep unconscious expectations concerning our abilities and our rights to touch and be touched,

must strongly color the motor intersubjective field.

Chapter 14

THE INFANT AND EMOTION

So far I have said little about the "affect" part of affectmotor schemas. It has been important to separate out the more purely cognitive component -- the "motor beliefs". A motor belief is cognitive, as we have seen, but in an other-than-verbal sense. Motor beliefs partially determine how "self" and "object" are perceived. They come to structure what I have called the motor intersubjective field.

An affect is something more than a web of beliefs, however. It is something more than an immediate appraisal too. There is visceral physiological arousal, with the autonomic, hormonal, and central nervous systems all in play. There is a parallel activation of the motor system as well.

When an emotion arises the body has suddenly changed its relationship to the world. That allows appraisal, but it prepares us for action as well (Frijda 1986). With each form of affective state we let the world not only appear but also matter to us (Heidegger 1962). The various emotions are like the lenses for a camera. With each different lens some particular tonality

of the world can show up for us; and can move us, matter to us. Affects disclose.

How does an infant learn about that? This ability, or set of abilities, to use the body affectively to disclose and discriminate -- what are its roots? And how do the immediate caregivers help, or hinder, its evolution?

Suppose too the infant ends up with a deficit in this area - - i.e., suppose the capacity for affective disclosure is minimally or poorly developed. What will be the consequences for his representations of self and other?

In one sense the infant arrives in the world with functioning emotions. (Again, I use the terms 'affect' and 'emotion' interchangeably.) A series of distinctive facial expressions of affect can already be observed soon after birth (Izard 1971). In part they remain constant; elements of these same facial expressions will later be displayed by the adult in emotional circumstances. Ekman's (Ekman et al. 1972) and Izard's (1971) cross-cultural studies of adults have even shown that these basic expressions are independent of cultural variables. An adult Eskimo displays surprise or disgust in the same way (in part) as an adult Londoner. And both in the same way as a baby one week old. There exists a wired-in core of innate affective dispositions which is set to last a lifetime.

Yet in another sense the infant in the beginning has very little of what he must eventually acquire. These inherited affect programs trigger responses which are unmodulated and undeveloped. Regulation, sophistication, and the use of affect for

communication are yet to be learned.¹ So are all the expressive variations belonging to the infant's own culture -- that which makes a Londoner different from an Eskimo and different again from a New Yorker.

How does this evolution come about? Fortunately today we possess some beginning information.

The research of Virginia Demos offers several critical clues. Demos (1984, 1986, 1988), an experimental psychologist unusual in her feeling for the multiple dimensions of affect, has perhaps pushed these questions farther than anyone else.

Particularly insightful is a carefully executed study of the development of affect skills on the part of two baby girls (Demos 1986). During their first 12 months the two infants were observed repeatedly and extensively in their home environments.² Videotapes were also made and subjected to analysis. The focus of observation was upon the recurrent patterns of their mothers' responses to the infant's experiences of negative affect -- distress, anger, fear, etc. Studied particularly closely were transactions occurring whenever the infants cried.

Of special interest was that, on the one hand, the two babies were judged (according to certain criteria) to be temperamentally very alike in the beginning -- "easy babies,"

¹C.f. Lazarus' (1991, 194f.) critique of the concept of "affect program". Lazarus, a leading experimental researcher in the area of affect theory, argues that there must indeed exist something like innate programs. But it would be a mistake to think that affect consists of nothing more than such programs. On the contrary, later learning renders our affective dispositions much more complex. I am here taking a similar point of view.

²This project was actually a pilot study in preparation for an extensive re-evaluation of data acquired in a more ample longitudinal study. The two baby girls themselves were observed over a period of two years. The report on which I am drawing is an account of the first year alone.

both of them. On the other hand, the dominant caretaking strategies exercised in the two homes were highly unsimilar.

The mother of Cathy chose to respond to signs of distress as quickly as possible. Usually she would comfort the infant physically, picking her up, rocking her, carrying her, nursing, etc. Even mild fussing or restlessness would be enough to trigger the mother's move to a comforting body contact. And that contact, which was competently carried out, would normally sooth and quiet the baby girl right away. This behavior of the mother remained quite consistent throughout the twelve months under study.

The mother of Donna demonstrated a markedly different pattern. She too responded to distress, but consistently with a lag. Baby Donna was usually first allowed, for seconds or for minutes, to struggle on her own. This mother would see how the baby managed, and then would intervene only if and when it seemed that Donna's distress was continuing or was escalating.

Often the milder ranges of fearful or angry crying were permitted to endure for a while. If the crying then escalated to a more intense level, this would bring about a more active maneuver on the mother's part. At that point either she would provide some soothing body contact, or else she would try in some way to distract the baby's attention (e.g., with a toy or object). As was the case with the other dyad, these behaviors of Donna's mother stayed highly consistent over time.

In sum, we find here a provocative juxtaposition of two opposed caretaking ideologies. Both mothers were attentive, well-meaning, available. Both were conscious (as Demos determined through interviews) of what they were doing; the patterns were the result of intentional strategies. So even though the sample was tiny, and any conclusions therefore tentative, we

stand here to learn something interesting. What were the observable effects for the two infants?

The results were clearcut. Let's start with Donna, whose mother followed the respond-with-a-lag principle. Two major developmental consequences stood out.

(1) Starting around 3 1/2 months Donna noticeably altered her crying behavior. Some of the time she now cried just as she always had. But some of the time she cried in a new manner. This latter was a briefer, more muted cry. It was highly "economical," as Demos puts it, an "instrumental" cry now modulated so as to function as a signal. It was clearly coupled with an expectation that her mother would soon react in some manner capable of relieving her state of discomfort. This signal cry, moreover, showed itself in a fear/distress variation and an anger/protest variation (different sounds, and accompanied by different facial expressions). These two variations, in addition, represented only the beginning of what became a rather complex evolution. As the following months passed, Donna's repertoire of signal cries and, as well, of similar non-vocal body gestures, rapidly developed further.

(2) Starting also around 3 1/2 months Donna began to build up behaviors which part of the time served to regulate her negative affect states independently of her mother -- e.g., thumb-sucking, manipulation of physical objects, or simply allowing the negative state gradually to subside. By the end of her first year she appeared to have acquired a considerable ability to cope by herself with low-level discomfort conditions. With occasional exceptions, any more intensive negative affect state would then stimulate her to try more actively to signal her mother in a variety of ways.

Now compare the results concerning baby Cathy. Hers was the mother who tended at once to respond to any distress state by providing some or another form of immediate physical soothing.

(1) As opposed to Donna, Cathy on the whole failed to develop a modulated signal cry. This was true both for the distress/fear and for the anger/protest ranges. For the most part she cried little at all. And when she did, it was almost always with a "basic expressive" (Demos' term) form of cry: no modulation, no instrumental usage.

Her general emotional range as a result tended to remain comparatively narrow. She appeared to flatten affect from the start rather than permitting it to unfold and build up.

(2) Cathy also developed very little in the way of coping behaviors. Even towards the end of her first year, when a negative affect state did overtake her she displayed little ability to manage or regulate it by herself. Whether facing fear and distress, or facing anger, she seemed to have few resources. A kind of helpless passivity when challenged by negative emotional states appeared to be her dominant characteristic.

So what are we to conclude? There can be little argument. As Demos puts it, "affective competence" is by no means a wired-in given: it must be facilitated by the caretaking environment.

What made the difference for Donna was that her mother could allow her a certain "optimal band" of concrete experience of negative affects. These experiences were sufficient for Donna to undergo a learning process, yet seldom so intense as to become overwhelming. As a result Donna could get to know them, could feel them in their distinctness, could learn to discriminate them. Equally important, Donna could develop a representation in this area of her own agency. Her own actions, she could discov-

er, "make a difference." Both with respect to signaling her mother, and with respect to her own management strategies, Donna could progressively build up a sense of effectance.

Whereas for Cathy the conditions were very different. She had few chances to develop an expectation that she herself actively might alter such states of emotional upset. It was always done for her, if with the best of intentions.

This meant, to begin with, that she could not acquaint herself in the same fashion with her own body: "one important source of information, namely that coming from internal affective signals, was being short-circuited" (Demos 1986, p. 64). It meant too that she couldn't learn in these situations how to signal, to appeal to, to communicate with the other -- the other was instantly already there. And finally it meant the self-regulation of emotion remained for her an unknown territory. Passivity, "dampened" affect, and a reduced sense of effectance appear to have been the price of her mother's ideology of protectiveness.

Thus we see here still another manner in which early experiences influence both self-object differentiation and self-object connectedness. On the one hand, where there is intuitive respect for the infant's autonomy he can build up a stronger sense of self-as-demarcated-from-other. Negative affect becomes a domain where he gets to know his own management maneuvers, his own coping strategies. Specific new skills thus permit an important extension of his primitive awareness of personal agency.

On the other hand a new mode of bridging to the other can now also be developed. That the other responds, but with a critical lag, creates a kind of opening up of another dimension of interpersonal space. Affective signals -- a rudimentary mode

of communicating with the other -- now become possible in this space. The bodily self-who-can-bridge and the bodily other-who-can-be-bridged-to can thereby acquire an added layer of phenomenological presence.

Note, incidentally, how these studies also permit us to amplify the traditional psychoanalytic concept of "optimal frustration." The notion of optimal frustration bears up well; clearly it was on the right track to begin with. But it can now be made more precise. That the infant learns "delayed gratification" (substitution of the "reality principle" for the "pleasure principle") is only a small part of what optimal frustration should accomplish. Taken by itself, "delayed gratification" is too passive a concept -- it suggests a kind of acceptance of the reality of time, a kind of waiting. Instead what counts is the building up of active skills: (a) capacities independently to manage affect, and (b) capacities to signal.³

The more recent analytic concept of "internalized self-soothing" (the mother soothed the infant well, the infant internalized her actions) also lies close (e.g., Blank & Blank 1974, Kohut 1977). But with this notion too a critical step is left out. The caregiver must not only "soothe" well (e.g., consider the example of Kathy's mother), but also provide the necessary space and support for the development of the corresponding autonomous skills.

If we pass now to some of Daniel Stern's research we can

³Freud's (1926) concept of "signal anxiety" also nicely prefigures this idea. Granted, for Freud the "signal" was seen as internal only -- the unconscious ego flashing a warning to the conscious ego, so to speak. Nevertheless a rudimentary notion of communication is thereby implied.

clarify these developmental processes concerning affect still further. Stern (1971, 1977, 1983, 1985, 1989) has demonstrated with finesse how certain parental procedures can foster self-object differentiation in the domain of affect -- or stifle it. As opposed to the caretaking strategies just described, the parental behaviors pinpointed by Stern are, for the parent him/herself, almost entirely unconscious. But their effects are none the less telling.

Demos focused upon the degree to which the caregiver could allow the infant to struggle on his own. Stern's studies illuminate an almost opposite factor. How does the parent interact, rhythmically, at close quarters? When the infant shows signs of feeling emotion -- any kind of emotion, sadness, anger, joy, etc. -- what are the exact nuances of the parent's bodily response? And what do these nuances do to the infant?

Stern's team similarly observed a number of mother-infant dyads during different progressive periods of the infant's first year (Stern 1985). The mothers and infants were videotaped. However, the tapes were analyzed from a different point of view. Demos focused upon large behavioral units (infant cries, mother crosses room and picks up); Stern focused upon minute ones.

We have already seen how, starting from the first days after birth, infants and parents exchange rhythmic body signals faster than the naked eye can follow. Stern looked more closely at what happens to this exchange when the infant begins to display some particular affect. In a number of different affect areas he pinpointed the infant's first display of emotion -- and then the mother's immediate nonverbal response -- and then the infant's response to her response, etc. Along with affects in the usual sense (e.g., sadness, anger, curiosity, surprise) he also studied

changing degrees of expressive vitality (i.e., the body suddenly appearing more lively or less lively, independently of a particular affect state).

What was shown is, I think, nothing less than extraordinary. It turns out that how the parents control the nonverbal dance radically shapes the infant's relation to his own emotions. A kind of sculpting is going on, and it operates with an almost unbelievable finesse.

This influence is transmitted by what Stern calls "matching" or "attunement".⁴ A typical sequence takes place as follows. First the infant expresses himself with body movements (and perhaps vocalizing too) of a certain intensity and timing. The mother with her own body then duplicates ("matches") either the intensity or the timing or both. For example, the infant, happy and excited, starts banging a rattle against the floor; the mother moves her own body, jiggling a hand against the boy's back in the process, with the same rhythm.⁵

Sometimes the mother "matches" in a different sensory mode. Perhaps the infant lets out several exuberant "aah's"; the mother matches by shaking her shoulders in the same rhythm. Or, looking frustrated and annoyed, the infant struggles to grasp a toy out of reach; the mother accompanies with a series of tense "uuuh...uuuh....uuuh's". Stern calls these "cross-modal" re-

⁴Actually "matching" is for Stern a wider category than "attunement." The latter, a more specific and complex form of matching, only begins when the infant is around age nine months. The difference is clarified later in the present chapter.

⁵Space here doesn't allow me to do justice to the subtlety of Stern's analysis. For example, what I have here referred to as the intensity and timing of the infant's expression, are further broken down by Stern into a series of subfactors -- e.g., timing in the sense of beat, timing in the sense of duration, and so on (p. 146f.).

sponses. Of course, on both sides some body movement is still bound to be in play.⁶

How does this action of the mother (or other caregivers) come to shape the infant's affective world? *Chiefly through selection and through rhythmic manipulation.* All of which is carried out unconsciously on the mother's part (as Stern determined from interviews).

The operation of selection is more easily understood. A parent may well match certain emotions and not others. This amounts to a form of reinforcement. Say, for example, that when the infant displays anger and pleasurable joy he consistently receives the wanted matching; and when he displays sadness, consistently not. That will tend to develop (and perhaps even overdevelop, distortedly develop) some of the affectmotor schemas having to do with anger; and tend much less to develop those having to do with sadness.⁷ We must conceive of the infant as having an innate hunger to encounter rhythmic matching. This is a force in him so powerful it can easily override other motivations.

Note, by the way, how easily the following could happen. It is perfectly possible for a caretaker (a) through out-of-awareness matchings and attunements to encourage a particular emotional expression to flourish, and (b) on the level of conscious, overt criticism to attack and punish that very form of expression! An important point, in my opinion. It is a commonplace in

⁶Stern's (1985, p. 141) "cross-modal responses" mainly involve exchanges where vocalization plays a strong part on one side but not the other. A's signal is body-plus-vocalization; B's signal, body alone (with either party being A or B).

⁷C.f. the "boxer baby" described by Esther Bick (1968).

family therapy theory that the family system may "require" (for reasons unconscious to all) a child to adopt a certain "slot" in the system, i.e. to take on a particular behavioral role. But it seldom has been explained exactly how the others manage (again, unconsciously) to groom the child for this systemic destiny. Stern's account offers a very plausible hypothesis.⁸

More subtle is the operation of *rhythmic manipulation*.⁹ Here the mother does match, nicely duplicating the infant's rhythm -- at first. But the mother then transforms the dance. There are two possible ways in which she may do this, "underattunement" and "overattunement".

Some mothers, for example, systematically "underattune" to the infant's intensity or rhythm. In that case she starts out by duplicating him, but then at once shifts her own expression into a slightly lower gear -- with the effect upon the infant that he follows her! Though underattuning, in other words, she dampens the infant. She pervasively trains him to reduce his expression, to flatten it. This learning process is so powerful that the infant, as Stern shows, will become habituated to flatten his affectivity in the same manner even when the mother is not present. It may be only in certain sectors of feeling (e.g., sadness, or explorative curiosity) that he learns to dampen himself; or it may be more global. It may be only a slight flattening; or it may be quite pronounced.

"Overattunement" is an opposite shaping style. Here the mother "enters" the infant's expression, matching his intensi-

⁸C.f. Stern's remarks on the interplay between the mother's deeper phantasies about her child and her concrete attunement actions (1985, 1989). C.f. also Brazelton and Cramer (1990).

⁹The term is my own.

ty/timing level; then she moves into a higher gear, pulling him up with her. She excites him, she jazzes him up. If that occurs on a regular basis the infant will acquire a regular tendency to exaggerate his expressive level, to edge it up several notches higher than his natural bent. He will even tend to do so, as was the case with underattunement, in situations where the mother is no longer present. Here too it may be a single emotional area which is influenced, or many. All depends upon the mother's unconscious scenario.

We can now clarify the difference between "matching" and "attunement". Matching, as Stern points out, is a more simple process. The caregiver just more or less duplicates the infant's rhythm. Attunement starts out as a duplication but then evolves into something else. When a parent attunes she/he picks up a rhythm only to subject it to a subtle transformation.

Healthy attunement appears to work like this: the parent plays the infant's own rhythm back, but with small variations -- the way a jazz musician might take up a melody from another player and then send it back slightly changed. The parent here stays within certain parameters; he doesn't lift the infant out of his own, the infant's rhythm.

Stern speculates that healthy attunement must provide an important learning process for the infant. He is finding out new variations of how emotions work, of how the music can be played. Attunement educates about what can be done with an affectmotor schema. It shows options, stylistics, widened possibilities. It demonstrates how the innate motor program can be transformed and

refined.¹⁰

Affect attunement must also be an important stepping-stone to the infant's dawning grasp that *other persons possess inner states*. So Stern proposes; and the idea seems reasonable. If the infant is presented, by the adult, with a series of abstracted transformations of his own inner state, then this amounts to a kind of educational theater. A felt inner state is one type of thing, teaches this theater, and an outer expression of it another. The infant is discovering how there can be two possible points of view upon affective states: a lived-from-within point of view (his own) and a seen-from-without (the adult's). Doubtless to state in this way what the infant learns is to overstate it. But something in this direction would seem a likely effect.

On the other hand, the potential negative consequences appear to be dramatic. Everything rests upon how this extraordinary instrument is used by the parent. If there is considerable mismatching, or underattunement, or overattunement, consider what that must mean for the infant's representations of self and other.

First, there has to be a major loss for the representation of the self. Entire areas of affective self-contact cannot evolve, or can evolve only distortedly. What we often call "parts of the self" will be denied adequate development.

¹⁰Probably healthy attunement teaches not only what one can do with affectmotor schemas, but also how these schemas fit the external world. This aspect is not emphasized by Stern, but it seems implicit in many of his descriptions (e.g., the mother attunes to the infant, and provides a kind of affective commentary, as the latter struggles to reach a rattle). Emde's (1983) research about "social referencing" also demonstrates the importance of such affective commentaries. As Stern himself points out, the phenomenon of attunement attains its full complexity around the same time (9 months) as social referencing first appears.

Second, a chance has been lost to add a new layer to the representation of the other. Through attunement the infant ought to be learning about the other's subjectivity, a subjectivity connected with, yet different from, his own. But this opportunity is now fated, in part, to go unrealized.

Third, there are obvious consequences for self-object differentiation. A deep confusion will have been created at the very center of the infant's affective experience. His rhythms have been stolen away; something foreign has been substituted. Stern (1985) gives poignant concrete examples. A mother "slips inside" the baby's emotion, she "robs" him of its original direction, she covertly practices "emotional theft" (p. 213). She enters "by way of attunement and then steals the affective experience away from the child" (p. 214). This means that the infant can no longer discriminate what belongs to himself as opposed to what has been introduced from without.

An example. Stern's videotapes of the infant Molly and her mother showed how the mother

overcontrolled the interaction to such an extent that it was often hard to trace the natural crescendo and decrescendo of Molly's own interest and excitement. It was so frequently derailed or interrupted that it could hardly be said to trace its own course....She gradually became more compliant....Watching her over the months was like watching her self-regulation of excitement slip away (p. 198).

In such situations the infant's body has become the puppet of the other. One is reminded of the anorectic patient who spoke of

"wires" coming from an undisclosed other. With respect to the malignant forms of attunement few metaphors could be more exact.

Such patterns of interaction, says Stern, must "throw open to question the infant's sense of and evaluation of his or her own internal states". Precisely -- because there are no longer his internal states. The infant's own body has become a source of betrayal. Within the specific affect sector which has been compromised he can no longer trust his inner signals.

Lacan (1977) in his teachings returned over and over again to what he called the question of desire. Much of his theory about desire changed during the years, but one central tenet remained constant. Lacan thought that one of the basic purposes of therapy is to help the client disentangle his own desire from "the other's desire" -- i.e., to separate it out from the desire of mother, of father, etc.

Stern's findings allow us to make this insight still more concrete.¹¹ Experientially it is our emotions which are the bearers of desire, every emotion containing within itself a series of implicit or explicit wishes.¹² Whenever there exists a profound entanglement of self and other in affective experience, there can be little recognition and ownership of one's own desire.

¹¹Green (1973, p. 136f.), in what in France has become a much-cited critique, accuses Lacan of ignoring affect. I think this is not quite right. More accurate would be to say that Lacan assimilates affect to the concept of desire.

¹² C.f. Lazarus (1991) and Tomkins (1961, 1962, 1991).

Chapter 15

STERN AND MAHLER: SORTING OUT THE DEBATE

We have not finished yet with the dispute between Stern and Mahler. I want now to consider another piece of the puzzle. An essential piece. To repeat, this Stern/Mahler controversy reflects questions of great importance for body psychotherapy. At issue is our most basic grasp of the preverbal period. To a degree for object relations psychoanalysis, and even more for body psychotherapy, whatever position we come to will have a direct influence upon how we respond to certain events and experiences in a therapy. The ideas may be abstract, but their implications, clinically, are extremely concrete.¹

Up to now I have discussed only some proposed revisions of Mahler's theory. These modifications preserve her best insights, I have suggested, while at the same time bringing her standpoint well into line with some of the major findings of recent develop-

¹By far the most thorough discussion of the clinical implications of the Stern/Mahler dispute is Dornes' *Der kompetente Säugling* (1992). Dornes book is a model of clarity. What is missing, however, is a more critical evaluation some of Stern's claims, which Dornes tends simply to accept at face value.

mental research.

But what about Stern's side of this debate? Should any comparable clarifications, suggestions, proposals be made?

I think yes. Surely it is apparent by now how much I respect Stern's superb attempt to build a coherent overall account of early development. Respect need not preclude balanced discussion, however. Indeed it is a measure of Stern's accomplishment how much we stand to learn even from a critical re-examination of his hypotheses.

I will go straight to the main point. There remains a seeming major obstacle to everything I have advanced so far concerning revisions of Mahler. It is this. According to Stern, or at least according what Stern at times claims, the very notion of self-object differentiation -- Mahler's great theme -- is moribund.² When we speak of it, he implies, we are invoking an obsolete concept. The idea of a gradual, progressive, stage-by-stage separating out of self and object has now been demonstrated by research data to be a fiction.

On what grounds? At first glance Stern has put together an overwhelming argument. In its basics his claim goes like this. (a) The infant from the beginning has a distinct perception of self. Much experimental data can be assembled in support of this conclusion. It is a rudimentary perception, but a stable one.

²Interestingly, Stern is not consistent in what he says about Mahler. Whenever discussing Mahler in detail he takes a more polemical hard line. However, at other times (but in passing, with little explanation) he mentions Mahler more approvingly.

Why? I suspect the clarifications offered in the present chapter allow us to make more sense of these contradictory attitudes. There is, as will be shown, a meaning of the concept of self-object differentiation which Stern is right to attack, and another meaning which instead merits support.

(b) The infant from the beginning also has a perception of the other, a perception equally stable, equally distinct. (c) Therefore there exists no diffuse fogbank of amorphous experience which must later acquire differentiation. Visual shapes already have contours. Qualities of movement, rhythm, sound, and even smell can already be recognized as separate. A world with a demarcated self and a demarcated other is a given for the infant beginning with day one, or close to it. Self-object differentiation is therefore in no way an achievement. It is the immediately operative counterpart of a predesigned, built-in perceptual capacity.

I think this far-reaching critique Stern has made teaches us much. I think as well it can be quite effectively answered. Where we end up once it has been answered, moreover, is with a somewhat changed understanding of the concept itself of self-object differentiation. Stern forces us to clarify and resolve certain contradictions and shortcomings. This is only advantageous. Especially since, as we will shortly see, the changed version of the self-object differentiation concept proves substantially better for explaining those adult clinical phenomena which the original, more confused concept had been meant to illuminate.

We need first to take a step back, however. A key to this Stern/Mahler dispute would seem to lie in the nature of perception itself. And in the characteristics of the phenomenological field in which perception functions. A general problem, when thinking and talking about infant perception, is that we easily forget how imperfect is our understanding of adult perception in

the first place.³ Then, when formulating our guesses about infant perception, we tend unthinkingly to transpose the same ambiguities and limitations.

Heidegger (1962) in a long and careful analysis has distinguished two ways in which we phenomenologically encounter spatiality. This distinction turns out to be of considerable importance for our question.

One is when we focus upon what might be called *side-by-side spatiality*.⁴ When choosing to let this aspect reveal itself, we notice primarily the shape of physical things; and what sits next to what; and what is still and what is moving. This is the space of mathematically measurable location. The table and lamp are next to the chair and a foot more to the right stands the picture. Space in this mode is neutral and homogenous, in the sense that any one 'world-point' could be replaced by any other.⁵

The other way we encounter space is by focusing upon what might be called *in-order-to spatiality*.⁶ In this mode, which

³ "Nothing is more difficult to know than precisely *what we see*," comments Merleau-Ponty (1962, p. 71).

⁴My term. Heidegger's own terminology, notoriously recontrite, refers not to the two modes of spatiality themselves but to the types of thing and object which show up in them. To perceive things in the side-by-side spatial mode is, in Heidegger's vocabulary, to perceive them as *Vorhanden*. The operative indicator here is the "vor": things in this mode show up simply as *before us*, in front of us, spread out side-by-side. Macquarrie & Robinson, the translators of *Being and Time* (Heidegger 1962), translate *Vorhanden* as "present-to-hand", a questionable choice. Much better is "occurrent", the proposal of Dreyfus (1991), a leading commentator on Heidegger. "Occurrent" suggests simply a neutral observable presence, which is the sense Heidegger intends.

⁵ This space is equivalent to the *res extensa* of Descartes, Heidegger notes.

⁶Again my term. Heidegger calls this the perceiving of things as *Zuhanden*. Dreyfus (1991) translates *Zuhanden* as "available", Macquarrie & Robinson (Heidegger 1962) as "ready-to-hand". Both these solutions fairly well capture the sense

actually is our more habitual one, we perceive things as organized into practical action pathways. What stands out for us, is not that the table is sitting next to the chair which in turn rests next to and below the picture, but rather that on the table is some object we intend to put to use. (Or even that this object we seek to use is *missing* from its expected place on the table.) Our readiness for action, or the executing of an action itself, determines what becomes foreground. We know this space through a practical knowing; it corresponds to our projects, desires, manoeuvring, doings. What we see (or hear or touch, etc.) in this mode continually reveals instrumental contexts, possible means and ends.

Consider, to take an example from Heidegger, a hammer. We could focus upon its exact physical shape, its length in centimeters, etc.: that is one way to let it show up. In that case it is side-by-side spatiality which we are letting stand out in our perceptual field. We could attend as well, in the same mode, to its potentially "measurable" location: where it sits in relation to any or all other things in space.

But suppose we grasp the hammer and use it to drive in a nail. This is to let the hammer reveal itself in a wholly other manner. When hammering, or even when just intending to do so, we encounter the hammer in in-order-to space. It presents itself as embedded in the what-is-being-done, or in the what-might-be-done. It shows up as at hand, as available, as ready to meet our body and our bodily skills. (Even if it is unavailable -- its handle is broken, or it has fallen behind the sofa where I can see it

of the "zu": the perceived thing shows up not just as "before" me in a neutral sense; it shows up as embodying a more immediate, active relation "to" me. In the "zu" mode, the thing and I have a certain fundamental involvement with each other.

but cannot reach it -- it nevertheless still shows up as revealing some variation of its availability.) Perceived in this mode, the hammer offers itself as belonging to a potential context of purposeful activity.

Now back to our controversy about self-object differentiation. What about the infant? Does he\she already (i.e., at birth or soon after) have at his\her disposal both these modes of spatial perception? And if so, what does that imply?

The research data here leaves no doubt. The infant knows nothing about operations of measuring, naturally, but he has the ability to perceive a rudimentary version of the type of space where the concept of measurement can one day come into play. He can estimate the contours and shapes of objects. He can tell which ones are moving and which are stationary. He has a rather good sense of location. "Over there", "over here": he doesn't have the words, but he has the intuitive perceptual forms. This is a differentiated field, and patently includes self-object differentiation: *in the sense of assigned location*. "Mother-body over there", "perceiving self-body over here": not the words, but the perceptual intuition.

But what about in-order-to spatiality? Here, much evidence shows, we have quite another matter. The demarcation of space into instrumental pathways must be learned, or at least in important parts it must be learned. Think of the still-face experiment (chapter 12). At three months some infants perceive the immobilized mother-face as reachable, as (by the infant) remobilizeable; and some do not. For the former an action pathway shows up in the perceptual field; for the latter this pathway

does not exist.⁷ For the former the field has a critical set of differentiations -- object as mobilizeable, self as having the power to mobilize -- which for the latter the field lacks. Thus what must be built up progressively, and with every chance of some degree of failure, is a practical knowing of action contexts in a self-with-other setting. It is the self-body as a source of agency and powers which must become distinct, differentiated. And, together with this, the other-body, the object-body, as that which can be reached, as that against which boundaries can be set, and the like. What is at stake here is a discrimination not of respective location but of the in-order-to phenomenological field.⁸

More can be said. Once we understand in this way what self-object differentiation really means, we are in a position to make our thinking about both infants and adult psychotherapy patients substantially more precise.

Let me go back a moment to Heidegger. Two additional comments should be made.

First, Heidegger in the usual examples in his writings spoke mainly about the perception of sophisticated components of a very adult world: tools, street signs, etc. He chose not to concern himself with childhood developmental stages, nor with the ques-

⁷The still-face experiment is in fact a fine example of what Heidegger (1962, p. 102f.) calls "conspicuousness" (Aufälligkeit). Sometimes it is precisely when action pathways fail to function in their accustomed manner that our implicit understanding of them becomes most apparent. Heidegger's own example is of a tool which unexpectedly doesn't work, but the same analysis here applies nicely to the infant's perception of the mother's body.

⁸Stern does attempt to deal with issues of agency as well. But, as I will try to show shortly below, the rest of his account in no way solves the problems I am raising.

tion of how in-order-to discrimination skills come to be acquired. So I am here adding a suggestion, based upon recent developmental research data of the kind already cited. It is the hypothesis that (1) the infant can only acquire these skills by practicing them, and (2) he can only practice them by being effectively guided in the right manner by the adults in his ambient. His body must go a number of times through the right actions before the instrumental pathways can become strongly demarcated in his perceptual field.

Second, Heidegger also elects only rarely to discuss the perception of other persons. In his chosen examples the interpersonal and the intersubjective tend to be present merely as an implied background: e.g., tools, street signs, or for that matter language itself all carry an implicit reference to a human community.

This means we must supplement Heidegger's categories when we consider the infant's preverbal interpersonal experience. Heidegger normally talks about a perceiver -- let us designate her/him as A -- and a perceived thing -- let us call this B. He then explores different possible relations between A and B. But when considering the genesis of the infant's discriminatory powers (in the in-order-to⁹ sense), we are forced to speak about another person, the caregiver adult -- let us designate this lattermost as C. Of course in reality there might be more than one caregiver present. But for the moment this tripartite structure, A-B-C, will serve our purposes.

What is especially interesting here, with respect to the infant's learning process, is the negotiation and struggle be-

⁹I.e., the *Zuhanden* sense.

tween A (the infant) and C (the caregiver.) This is one of the stunning major themes brought to light by much of the recent research. Are the infant's cues and signals respected or not? Is he\she allowed to initiate connection? Is he\she allowed to disconnect and to set boundaries? Is his\her interactional rhythm met by the other? Is his\her rhythm not only met, but also allowed to have its own variations and intensities, rather than having these imposed from without? And so on. We have already seen a number of examples.

We should distinguish, it would seem from the concrete experimental findings, at least five different "territories" -- one is forced to metaphor -- of negotiation and struggle.

1. The territory of personal corporeality. This is the infant's physical body itself. The drama which must unfold concerns access to and powers over this small unit of physical extension.

Remember, an essential reality about the body is its double nature, as Merleau-Ponty (1962) so often emphasizes. My body is both something I inhabit from within, and at the same time a physical thing among things. And so of course for the infant's body as well. (Recall that some motor control is present at birth, and that the infant has a more than purely reflex usage of that motor control.)

The tripartite structure which will determine the demarcations of this territory is therefore as follows. A is the infant as agent -- an embodied agency, a sense of agency inhabiting the body from within. B is the infant's body in its other sense, an extended physical unit which can be perceived from the outside. C is the caregiver.

This struggle between A and C concerns the infant's grasp of his body as a physical unit over which either he or the caregiver can potentially exert control.¹⁰ Thousands of nonverbal negotiations must take place, their medium being touching, handling, lifting, carrying, bundling, dressing and undressing, and the like. Their cumulative outcome will determine the infant's sense (as agent) of ownership, or lack of ownership, of his corporeality (as thing-body).

In the beginning this sense of ownership will be minimal: unknown and undifferentiated. As the months unroll it will evolve; but to what degree is open. Tremendous variation appears to be possible. At one extreme, we can hypothesize, there will be developed a strong early sense of possessing one's own body. At the other, the result will be an extensive learned helplessness: passivity, absence of control, an undemarcated void in the place where agency should have been present.¹¹

2. The territory of the other's body. Here it is the infant's access to and modes of contact with the other's body which is in question. Can he initiate contact with the caregiver's body? Is the other's body perceived as accessible, and as accessible in a variety of ways?

Then there is the question of the fate of the infant's contact once he has initiated and undertaken it. How is his

¹⁰I don't mean to claim that the infant already has a representation of how the other might see the outside of his body. That is a development which comes only at around 18 months (c.f. chapter 16). The early interactional patterns which establish, successfully or unsuccessfully, a sense of ownership about the body are more primitive than this.

¹¹I have in mind especially Seligman's (1975) concept of learned helplessness.

contact accepted? How does the other respond with breathing, posture, movement, etc? Does the infant learn that his contact "produces" (on the side of the other) a stiffened, breath-held body? An accepting body? An overaccepting, demanding, exploiting body?¹²

The other's body-as-physical-thing is naturally here the third term in the tripartite structure.

3. The territory of the intermediate zone. This is the space between the self and the other. What is negotiated is the access to and control over things which show up in this space: a toy, an eating utensil. The second term, the "B" between A and C, is of course here the physical thing itself.

Largely it is at age five or six months that this territory becomes an important site of negotiation.¹³ Play with a toy, for example, may be subjected to a co-operative style of adult intervention, the infant's own motor initiatives and actions being respected and encouraged. Or the adult's interventional style may be overcontrolling; or it may be underinvolved.

So too with the struggles over food and eating utensils. With this complication, naturally: that destination (at least in the adult's plan!) of the food is entry into the infant's body. The evolution of eating practices and rituals therefore encompasses both the territory of the intermediate zone and the terri-

¹²I don't mean in a directly sexual sense, though this of course is a possible and especially pathological variation of the other's body as overdemanding.

¹³C.f. Winnicott's (1958) intriguing comments on the "Spatula Game". Winnicott would place a tongue depressor where an infant who was sitting in his mother's lap could reach for it. He would then draw ingenious diagnostic hints from the ensuing actions and interactions.

tory of personal corporeality.

Another type of transaction in the intermediate zone begins around age 14 months: the infant repeatedly brings physical things to show to his caregivers. Here too a wide range of forms of interaction is possible.

An open question is the relationship among these three different familiar situations: (a) infant and caregiver jointly concern themselves with a physical thing, (b) infant plays with/manipulates a physical thing while the caregiver is nearby but uninvolved, and (c) infant plays with/manipulates a physical thing while entirely by himself. How much does the infant's experience in any one of these situations determine how he approaches the others?

4. The territory of affect. We have seen in previous chapters how subtle and complex the negotiation of this territory tends to be. Demos (1986, 1988) has shown how the caregiver may or may not give adequate room for the learning of coping experiences with negative affects. Stern's own research demonstrates how though attunement and misattunement the caregiver can either encourage or override the infant's own affective responses.

What is the second term, the "B" here? There would seem to be two of them, or two levels of a second term.

First, and most importantly, there is the dance itself: the mutually constructed bodily back-and-forth. This is an active doing; it is not just a feeling the body. The product of this doing, so to speak, is a two-person rhythmic configuration. The question of territorial rights and powers concerns who is permitted to put her/his stamp upon the configuration.

We can speak at times of another level of the second term

too: there may be an outside object or target of the shared emotion. Infant and caregiver may both be responding to a sudden noise, a piece of music, the antics of a pet. Emde's (1983) studies of "social referencing" make clear how, in many situations, the infant looks to the caregiver for cues how to respond. (Robot with bells and lights enters room. Infant looks to mother for signal whether to react with laughter or fear.) This is a more complex tripartite structure. It is partially akin to that of the territory of the intermediate zone. The difference is that affectivity here concerns the choice of what emotional stance to take towards a thing, not the choice of who should control any ensuing physical interactions with the thing.

5. The territory of language. Here the territory is what is said with words. The tripartite structure is similar to that of affect. A joint configuration -- a dialogue, a verbal exchange -- is mutually constructed. The question of rights and powers here concerns who is permitted to modulate and transform an on-going exchange.

As my intention in these chapters is to focus upon the preverbal period, I will not raise further issues about this domain. Except one. From three months onwards the infant engages in rhythmic exchanges of vocalizing and babbling with his caregivers.¹⁴ To what extent do these interactions lay a base for later struggles for power over language?

An aside, before going further. For Mahler, Edith Jacobson (1964) and others in the object relations psychoanalytic tradi-

¹⁴See for example de Villiers & de Villiers (1979, pp. 19-33).

tion, the whole point of thinking in terms of self-object differentiation has been to clarify certain conditions and defensive actions presented by patients. I would suggest that to think in terms of these "territories" gives much more clinical exactitude when working with patients.

In reality it is almost never the case that an adult patient loses, or even fears to lose, his sense of the *respective physical location* of himself vis-a-vis another. He may fear that the other will control his body, or that the other will control his feelings or thoughts. He may fear that the other will invade him sexually, or intrude upon him in other physical modes, or poison him, or implant unwanted emotions or impulses.

A vast range of anxieties is possible here, some of them quasi-realistic and some of them bizarre to the point of psychosis. But they are much better understood as fluctuations in an imagined distribution of power and agency, rather than as a dissolving of physical location.¹⁵ Even a schizophrenic patient

¹⁵Compare how similar is this remarkable statement made by Edith Jacobson in 1987. Jacobson, for the reader unfamiliar with her work, was, together with Mahler, one of the two main architects of the concept of self-object differentiation in current object relations theory (c.f. especially Jacobson 1954, 1964).

In a letter to Fred Pine (quoted Pine 1990, p. 241) she says the following. "The dilemma of the psychoanalytic clinician and teacher, of course, is how to keep abreast of these new data [i.e., from experimental research such as Stern's], and integrate them into our thinking, without prematurely jettisoning valuable clinical concepts, such as the various symbiotic phenomena....The severely narcissistic or even schizophrenic patient who might satisfy for many observers the criteria for inferring a merger state with mother, would still in many observable everyday behaviors appear to treat her as a separate individual and would therefore demonstrate apparent self-object differentiation on an adult equivalent of the perceptual tests used in early infant observational research. He looks towards her when she talks, doesn't try to occupy the same chair that she does, etc. And yet he might satisfy us clinically that unconsciously he firmly believes the two of them to be 'really' one, sharing thoughts, affects, bloodstream, nervous system, and fate. What we are referring to in

hallucinating voices tends to hear them as coming from a point slightly outside of himself. I can only say that for some years now, supervising cases in psychiatric hospital settings, I have found the above notion of "territories" to be extremely helpful. As have the therapists I have worked with. One determines not just that the patient fears "merger", or lacks an adequate sense of differentiation. One determines more precisely with respect to which territories this condition applies, and in what ways.

The main point about self-object differentiation, and about the dispute between Stern and Mahler, is the one just made. But more must be added. An objection could be raised to what I have up to now said.

The objection might be expressed so: doesn't Stern's argument touch upon other themes as well? Doesn't he break down what he calls the infant's "core self" into several different components? Might not what he claims about the other components in some way rescue his strong position against the hypothesis of progressive self-object differentiation?

I will therefore briefly turn to these other claims. I think it can be shown quite clearly that they have some additional weaknesses, and that as a result they bring about no substantial change in the overall picture. To look at these details is also worth the trouble, it seems to me. Let me underline one more time how high the stakes are here. Our most funda-

these instance as 'merger' is, of course, an inferred unconscious fantasy or affective experience of merger, an enduring or repetitive ego state, rather than an intellectual assessment by the patient." If the last comment of Jacobson is a little vague (fantasy of what type of merger? repetitive ego state of what nature?), the notion of territories as described earlier in this chapter allows a more specific analysis in the case of any individual patient.

mental understanding of the nature of the preverbal past rests in part upon the issues under discussion.

The "core self", proposes Stern, is consolidated at around age two months. He breaks down the infant's awareness or sense of this self into four sectors:

(1) self-agency, in the sense of authorship of one's own actions and nonauthorship of the actions of others: having volition, having control over self-generated action (your arm moves when you want it to) and expecting consequences of one's actions (when you shut your eyes it gets dark); (2) self-coherence, having a sense of being a nonfragmented physical whole with boundaries and a locus of integrated action, both while moving (behaving) and when still; (3) self-affectivity, experiencing patterned inner qualities of feeling (affects) that belong with other experiences of self; and (4) self-history, having the sense of enduring, of a continuity with one's own past so that one "goes on being" and can even change while remaining the same" (1985, p. 71).

For each of these four sectors Stern cites research data which, he believes, substantiates our inferring that the infant indeed must have an awareness of a distinct and separate self. However, there are problems with this conclusion in the case of each sector.

First, the sense of "self-agency". Here the difficulty with Stern's reasoning can be simply stated. Stern nicely demon-

strates, drawing on research evidence, that the infant is capable of sorting out when he is moving his own arm, as opposed to when the caregiver is moving his, the infant's arm, and the like. So we can indeed assume that the infant has some sense of agency. But the great question is, how much? To what extent? In what domains, for a given infant, is this capacity for sensing agency in fact actualized? As just shown above, we have good grounds for concluding that, in some cases, the sense of agency may well remain undeveloped in several critical domains. To put the problem in different words: Stern demonstrates only possibility but assumes actuality.

Second, the sense of "self-coherence". This is where Stern's argument comes into its own. He has shown that the infant can discriminate his own body as a unit in space, as well as the other's body as a separate unit in space. As discussed above, it is at this point that we psychotherapists have no choice but to give up some of our long-standing assumptions about the nature of self-object differentiation.

Worth pointing out, however, is that even here Stern draws some conclusions which appear to go beyond the supporting evidence. What the research actually demonstrates, as he points out, is that young infants can discriminate the location of separate body-units *as long as sufficient cues are present.* For example, a series of experiments has shown that an infant who sees a face "expects" that the sound of the other's voice will come from the same visual location (Stern 1985, p. 82). Other experiments have made clear that infants can identify the temporal rhythm of both auditory and visual stimuli; and, as well, can perceive any existing synchrony between the auditory and visual

rhythms (1985, p. 85). In other words, they can "match up" the temporal rhythm of what they hear (e.g., the caregiver's voice) with the temporal rhythm of what they see (e.g., the synchronized movements of the caregiver's body). (For details about the relevant experiments themselves see Stern's text.)

But this raises an evident question. What about situations where the infant has less cues to work with?

One such situation is obvious. Pine (1990) has nicely discussed this point.¹⁶ What about when the infant is being held close against the caregiver's body, and is being presented with few visual and auditory cues? Will the discrimination of self and other continue to be so distinct?

Stern addresses this issue. But his analysis is less than satisfactory. He invokes the concept of "self-synchrony", which

refers to the fact that separate parts of the body such as limbs, torso and face tend to move -- in fact, must move -- together synchronously to a split second, in the sense that starts, stops, and changes in direction or speed in one muscle group will occur synchronously with starts, stops, and changes in the other muscles groups.

(p. 83)

In addition, these changes in movement occur synchronously with natural speech boundaries and the phonemic level, such that the temporal structure of self-syn-

¹⁶Pine, a former colleague of Mahler, here (1990, p. 232ff.) specifically replies to Stern's critique of Mahler.

chronous behavior is like an orchestra, in which the body is the conductor and the voice the music....In short, all of the stimuli (auditory, visual, tactile, proprioceptive) emanating from the self share a common temporal structure, while all of those emanating from the other share a different temporal structure.

(p. 84)

Therefore, he proposes, we can assume that even when the caregiver is physically close to the infant, the latter can put together enough cues from different sources to maintain clearly demarcated perceptions of self and other.

But this argument doesn't really help. In fact it begs the question. What about when the infant has to rely upon tactile stimuli alone? Suppose the caregiver is not making auditory sounds. And suppose the infant has his eyes closed. Or, that his eyes are open but he is positioned such that he cannot see the caregiver's body. Or, that his eyes are open but he can only see some portion of the caregiver's body (e.g., upper chest) which looms so large in his visual field there is no chance to discriminate movements against a separate background. Under all such conditions only the tactile cues are left. Are these sufficient, by themselves, to mark off distinct perceptions of self-body and other-body? Not only is this unproven, it is highly doubtful. Think of your own experiences of being, eyes shut, in close contact with another's body. Isn't a diminished ability to tell where one body stops and the other begins precisely one of the salient characteristics of such an experience? If this is so for an adult, might it not be all the moreso for a young infant?

Then there is a second conceivable situation in which an

infant might have less cues to work with. Stern makes a great deal, and justifiably so, of a peculiar behavior which adults tend to adopt when they are dealing with small infants: they exaggerate and caricature their own sounds and movements. The facial expressions the adults make, for example, are "marked by exaggeration in fullness of display, longer duration, and slower composition and decomposition of the display" (Stern 1985, p. 73). The "baby talk" the adults now engage in is "marked by raised pitch, simplified syntax, reduced rate, and exaggerated pitch contours." And so forth. (For a much more extensive account see Stern 1977, pp. 9-30.) Stern's excellent point is that this "packaging" by the adult of how she/he presents her/himself, provides the infant with an optimal set of distinct stimuli for learning about (among other things) how to differentiate self and other.

But suppose a given infant receives much less of this "packaging." Suppose the caregiver or caregivers in his ambient have less of this intuitive how-to; or even that, consciously or unconsciously, they actively pull back from such behaviors. What then is the implication for the infant? Shouldn't we expect him to fare less well with his building up of representations of self and other? Either (a) Stern is wrong about the importance of adult "packaging" of exaggerated behaviors, or (b) variations in adult competence in "packaging" must be correlated with variations in the infant's degree of learning of the self/other demarcation.

Third, the sense of "self-affectivity". Here it is above all Stern who must be cited against Stern! I have already mentioned, in other chapters as well as just above, how Stern's own

remarkable studies of affect "attunement" and "misattunement" show how easily the infant can lose a sense of ownership of his emotions.

Even Stern's own language, once he is concerned not with Mahler but with his own research findings, makes it clear that, in many instances, the infant can no longer discriminate what belongs to himself as opposed to what has been introduced from without. For example, Stern (1990) in his *Diary of a Baby*, a lovely small book in which he attempts a portrayal from the inside of an infant's experience, describes an encounter in which 4 month old Joey is looking at his mother. Usually through healthy attunement she heightens his emotional state. But this time, for a second or two, her face has gone lifeless. Here is Joey's response as imagined by Stern:

I enter the world of her face....This time when I enter, the world is still and dull. Neither the curving lines of her face nor its rounded volumes are moving. Where is she? Where has she gone? I am scared. I *feel that dullness creeping into me.* I search around for a point of life to escape to.

(p. 58, italics added)

Notice how porous the sense of self is here: Joey feels that the "dullness" is becoming a part of him, is invading his being. In these affective exchanges, the grasp of self and other is so intertwined that the infant is constantly vulnerable to a partial collapse of their differentiation. And this example, we mustn't forget, is from an idealized version of parent-infant relationships! (In the *Diary of a Baby* Stern describes only experiences

with caregivers who are highly sensitive and competent, a quite legitimate slant since his avowed purpose is to provide a sort of handbook to the parents of young infants.) As we have seen, when Stern elsewhere describes the effects of the less healthy vicissitudes of attunement, he chooses stronger words. A mother "slips inside" the baby's emotion, she "robs" him of its original direction, she covertly practices "emotional theft" (1985, p. 213). Or again, she enters his emotion "by way of attunement and then steals the affective experience away from the child" (1985, p. 214).

Fourth, the sense of "self-history". Here Stern patently claims too much.

The evidence which he cites shows nothing more than that a young infant already possesses some forms of recall memory. For example, a string is tied at one end to the infant's foot and at the other end to an overhead mobile (Stern 1985, p. 91). Infant kicks, mobile moves. Several days later the same mobile is presented, this time with no attaching string. The infant kicks a lot anyway, demonstrating a "motor memory" of the mobile. Similar experimental findings show that infants can recall a briefly perceived face (p. 92), a playful interaction with a puppet (p. 93), and the like.

But where is a sense of self-history in this? Does the infant "know" that he has connected up different experiences in time, in the sense of a reflective, thinking-about-what-is-happening, observing-ego knowing? That seems hardly likely; and in any case has not been demonstrated. Surely it is one thing (a) to perceive an event, and another thing (b) to have an awareness or knowledge of a larger time frame in which this event has its

place. Nothing in the research data Stern cites gives us the least indication of anything approaching (b).

Instructive in this regard too are some of Stern's own comments in his *Diary of a Baby*. Stern has just presented another "experience" from the point of view of 4 month old Joey. Then, in a commentary analyzing this entry in Joey's "diary", Stern (1990, p. 77) points out that

Joey so far experiences events as loosely or not at all connected in time. Thus, in Joey's text [i.e., Joey's "diary entry"], each distinct focus of attention or delimited experience is followed by ellipses indicating a probable gap in his experience. Joey is not yet old enough to be able to need to rework the sequence of his experiences into a coherent whole. Where adults feel fragmented and disorganized when they cannot render their mental activities into a reasonably comprehensible and coherent whole, infants of Joey's age accept their experience as they live it in the present moment. Here Joey has had at least eight *discontinuous and loosely related experiences*: being carried by his father; moving through the room; stopping and sitting; the flow of conversation; riding the tide of his father's breathing; looking at the window and recalling the morning sunpatch in his bedroom; the woman's laughter; and his father's physical reassurance. Each of these experiences exists separately in its own subjective time frame.

(italics added)

An interesting and informative passage. But could anything be farther from a "sense of self-history"? Again, in the same commentary Stern comments (p. 78) upon a moment in which Joey has first perceived some light coming in a window and then "remembered" -- i.e., had a mental image of -- a patch of sunlight experienced earlier that morning. Stern remarks that

Joey does not know that one of these images is a memory. He has simply two different forms of experience.

But where is a "sense of self-history" going to come from, if a perceiving subject is not even aware that a memory is indeed a memory?

Finally, suppose we were to grant, even though there is no evidence for it, that an infant might have some form of reflective awareness of being in contact with different time periods. How would this assist the task of self-object differentiation? Would it mean the infant would also have an understanding that the other, the caregiver, has her/his own separate awareness of a temporal history? That in no way follows. On the contrary, the little that we do know about small children's representations of the internal life of other persons, suggests it would be highly unlikely for a young infant to have so sophisticated a construct of the other's internal life. As Forguason & Gopnik (1988) have shown, there is much sound experimental evidence for the hypothesis that only at age 4 years do small children have enough of a "theory of mind" that they can represent to themselves the notion that a separate person lives the world from the point of view of

his own separate experiences and history.¹⁷

Finally, something should be said also about Stern's own timetable. Stern often talks, when he is arguing against Mahler, as if self-object differentiation were a predesigned given which is always present in the infant's experience. Yet it turns out that Stern as well posits a time period when there exists less self/other demarcation: months 0-2. This is what Stern labels the period of the "emergent self". Only with respect to the "core self", ages 2-7 months, does he propose that a clear differentiation of self and other can be assumed to be in place.

What is interesting about this is the following. If there does exist an initial period characterized by less self-object differentiation, shouldn't we expect that later in infancy an infant would often "dip back" into this former mode of perceptual organization? And shouldn't we expect that adult patients might in their own way also "dip back" into this mode? Stern (1985, p. 11) himself says that "once formed, each sense of self [i.e., emergent self, core self, etc.] remains fully functional and active throughout life." If the emergent self mode of organization remains active, and thus presumably at times might move to the foreground of consciousness, that would seem to imply plenty of room for experiences of reduced self-object differentiation both in later infancy and afterwards.¹⁸

¹⁷See also Gopnik & Astington (1988) and Perner (1993).

¹⁸A historical note is also worth mentioning. Stern's own timetable comes surprisingly close to that of Melanie Klein. What Klein (e.g., 1975, p. 61f.) called "the depressive position" she saw as emerging at age three or four months. And the essence of this developmental shift she saw as being the infant's new sense of the other as a "whole object", together with his sense of himself as a whole self. She postulated, in other words, somewhat the same achievement at close to the

To summarize, Stern has proposed that the concept of a progressive self-object differentiation in infancy is obsolete. A close examination of his argument, however, suggests that this concept is anything but obsolete. We do need to define more carefully what we mean by self-object differentiation. Some hypotheses of Heidegger, concerning different styles of our perception of things in space, provide a good means of doing so.

Lichtenberg - low, moderate, high
The more limited sense in which Stern is surely right,
regards the infant's perception of pure physical location. But *high*
the infant's sense of himself as an agent, and as a bearer of
emotion, is quite another matter. Here the hypothesis of a *intensity*
progressive self-object differentiation continues to apply well,
and indeed better matches the research data. *states*

Even with respect to the perception of pure physical location, it is possible that Stern's account is rather too totalizing, too "all or nothing". All the same, it must be granted that a strong degree of self/other demarcation of this lattermost type must be present for young infants, even if perhaps not completely firm and solidified. Stern's insistence upon that point is fully warranted.

Mahler's object relations perspective and the new infant development research thus turn out to be not at all incompatible. On the contrary, they fit together well. What is required is a

same age as Stern's consolidation of the "core self" and "core other".

Of course Stern's account of how the infant arrives there (through the exercise of interactional competencies) is highly different from Klein's account (through the gradual resolution of internal instinctual conflicts). Nevertheless the correspondence of the timetables is striking.

further refinement of Mahler's point of view, retaining her best insights while incorporating several major revisions. What is required as well, is careful analysis of the theoretical claims which sometimes accompany the new developmental research. This remarkable field is already bringing changes to psychotherapy, and certainly in the future will continue to do so. But it is worth everyone's while to pay attention to the inevitable gap between experimental findings and more generalized theoretical conclusions.

Chapter 16

THE FORMS OF BODY DEFENSE

We have made a long detour. The previous chapters have been concerned with infant development. By examining some of the most important recent research in this area, it has been possible to arrive at several general hypotheses about the early formation of what I have called the infant's intersubjective motor world.

We are now in a position to make use of these hypotheses. First, they prove quite helpful, as will be seen in the present chapter, for understanding certain aspects of body organization, body consciousness, and body defenses in adults.¹ Second, work with body regressive states touches at many points upon these same issues. That topic will be taken up in the two chapters which follow.

Just what are so-called body defenses? What is their nature? How do they function? What are their various types?

¹The same concepts can of course be used to understand the body experience of older children, a topic I will not take up here.

On the one hand, it has long been a commonplace that what persons do with the body -- tightening it, ignoring it, etc. -- may play a psychologically defensive role. Groddeck (1949a, 1949b) first pointed this out. Ferenczi (1926, 1955) developed the concept. Reich (1949) and others elaborated it further. (See chapter 19 for an overview of this history). Even Anna Freud's (1946) still influential *The Ego and the Mechanisms of Defense* supports the idea, if rather in passing. Most of the "new therapies" (Gestalt therapy, Transactional Analysis, etc.) acknowledge it as well.

On the other hand, there is much which is obscure about body defenses. Perhaps what is most surprising is how little we know about the developmental, the chronological emergence of body defenses. Exactly when for the child do they begin to function? And what are the exact steps of their formation?

You might reasonably enough counter that we know next to nothing about the chronological emergence of projection, splitting, repression, and the like. Theories about the emergence of such "purely psychological" defenses we have in abundance; but of hard empirical evidence, a paucity.²

This is true enough. Yet one can't help but feel wistful about the corresponding lack of hard evidence concerning the body defenses. That is because they make up a sphere which intrin-

²Incidentally this situation is quite the same in the body psychotherapy literature. One finds frequent assertions about which defenses arise in the child when (e.g., Lowen 1958).

I certainly agree whoever works therapeutically with patients must make speculations of this kind. But one would wish more acknowledgement that these hypotheses largely amount to pure guesswork. In the instance of body psychotherapy there doesn't even exist a body of supporting contributions from child therapy, as is the case with the psychoanalytic literature.

sically seems more accessible to developmental research -- even if this must mean the research of tomorrow. After all, we are talking mainly about actions *inherently observable from the outside*: movements, breathing, tightenings, loosenings. Granted, as we will see below, these are actions which for the most part are too minute to be easily documented and measured. Likely a technology more advanced than what is presently available would be required. However, an even more fundamental need in this area would be for researchers to start asking the right questions.³

I will now summarize some points about the nature of body defenses as I have come to understand them. I will refer at times to the preceding chapters on infant development. We are on a wholly other terrain now, however. Up to this point our discussion has been able to draw mostly upon specific research findings, and rather less upon "extrapolation backwards" from work with adult patients and older children. Now we are forced to become more speculative. Concerning the body and the body experience of an adult patient, there is much that can be described in a straight-forward, empirical manner: he reported himself aware of this and this in the body, and also the therapist noticed, from the outside, that and that about his body.⁴

³ For example it is extraordinary to see someone like Paul Harris, whose fine studies reveal to us so much about how children deal with emotions they find difficult, fail even to consider uses of the body as among the child's management strategies. This is especially surprising given Harris' penchant for confronting wider theoretical issues. In his otherwise excellent *Children and Emotion* (1989, p. 123, p.130) he even expresses puzzlement when, in response to interviewers' questions, children themselves spontaneously begin to introduce notions about the body!

⁴ I don't mean to imply that even observations of this kind are innocent of theoretical assumptions. Of course they are "theory-laden." But obviously not to the same degree as claims about the causal links between past childhood events and present body and personality organization.

But once we try to understand the meaning of such body conditions or events in relation to the childhood past, our uncertainty increases. In the discussion which follows I will try to make some reasonable guesses. I will also try to point out, in passing, which of these ideas have more support, and which less, in terms of what is known from existing research.

Body defenses seem to have the same aims as the "purely" psychological defenses like projection, denial, etc. Their function is to protect us from things we do not want to recognize or feel or do. In that sense they are of course no less "mental" than the purely psychological defenses. We call them "body" defenses simply because they more directly utilize either the physical body itself or our modes of awareness of it.

Body defenses operate quite neatly in tandem with the purely psychological defenses. A body defense also can operate in tandem with other body defenses: a particular feeling or thought may be defended against by several body defenses simultaneously, as well as by any of the purely psychological defenses too.

I will mention here ten different forms of body defense. Naturally these types to a certain degree overlap with one another.

1. *Underdeveloped motor schemas* represent the first type. Of course an undeveloped schema is a deficit; we are speaking about a developmental arrest. But in this case it is a deficit which also operates very much as a defense.

Take someone whose affectmotor schemas in the area of anger appear markedly undeveloped. This can be plainly seen during physical work with the body. For example, each time a trace of

anger surfaces, the person searches for possible aggressive movements (there exist a large number) to explore. But these movements are perceived as non-existent; or as unattainable, too difficult. Far beyond any elements of guilt or anxiety, the person experiences a deep body sense of "I just don't know how to do this". Something is as if omitted from his available affectmotor repertoire.

Now we can speculate that the most primordial layer of this "don't know how" probably did not originate as a defense. More likely in the patient's infancy it first amounted to a developmental arrest which was "cultivated" by the caregivers -- through selective attunement in Stern's (1985) sense, and the like. But in that case one must ask: why has the arrest remained ever since in its undeveloped state?

The question is very relevant. Because what one discovers in therapy is that these schemas "want" to grow. Though quiescent they are not dead. They are not in the least like organic bone whose chance to reach its full size is irrevocably lost once a given temporal phase has passed. On the contrary, such schemas possess an strong "self-righting" tendency, an easily-stimulated innate readiness for further development and refinement. So why has that never happened?

Obviously because the family system was such that it could not. As the child grew older he/she was subjected to continued systemic pressure to maintain the schema in its arrested state. That unconscious "maintaining" is strictly speaking the defensive activity itself. And normally it is a highly effective one. An array of other "anti-anger" defenses (both body and purely psychological) of course may well come to supplement it. But a powerful defensive nucleus has already been established whenever

certain fundamental schemas have been successfully cut off from any adequate opportunity for evolution.⁵

Remember too that these fundamental schemas play a critical role in the infant's construction of his representation of the other. A deficit here -- defensively maintained -- may thus have radical consequences for the entire motor intersubjective field. Suppose that, for a given patient, we are talking about a schema which includes as subschemas (a) reaching with the arm and hand to touch the body of the other, while experiencing (b) an affective state of combined neediness and tenderness. Suppose as well that this schema has remained weak and undifferentiated. In that case the patient's sense of agency available for such an action will be (in comparison say to reaching for a physical thing) tenuous, reduced, problematic. But likely as well his corresponding motor portrait of the other will be threadbare in "tactile accessibility." A body defense of this type can have many ramifications for both poles of the motor intersubjective field.

2. *Defensively distorted affectmotor schemas* are quite another affair. Here there has taken place more evolution of the schema, but with a pathological bent. The schema comes to be overused, and in what strikes an outside observer as an exaggerated manner.

⁵Naturally this can apply as well to schemas governing arousal or activation in general as well as to those mobilizing specific affects. Stern (1985), referring to the same phenomenon, has come to speak of "vitality affects."

I am not sure this is a happily chosen piece of vocabulary on Stern's part. Perhaps less confusing is his earlier (1977, p.63) more neutral concept of "excitement." General bodily arousal is highly complicated in its physiological substratum. There seems a value to retaining for its behavioral and phenomenological manifestations a term which carries a minimum of theoretical baggage.

Take for example a persistent militant aggressiveness. This might manifest itself in schemas activating the shoulders, arms and hands; the jaw and the eyes; the pelvis; or even the legs. Any one of those schemas might be predominant, or several might operate in combination. In an infant one will here find open, overt movements. In a adult the body activation is usually more controlled and subtle.

The underlying defensive purposes here at play can be many: warding off intimacy, defending against archaic experiences of humiliation, etc.⁶ And of course the body defense can easily function in tandem with various of the purely psychological defenses: e.g., denial, primitive devaluation, and projective identification (arousing in the other person feelings of intimidation and/or a corresponding hostility, for example).

3. *Countermobilization* is a body defense of a somewhat more complicated nature. Basically it is a movement which is generated in antagonism to a preceding movement -- on the whole, an elegant and efficient strategy! For example, a child becomes sad. One of the subschemas thereby mobilized stimulates an opening of the throat in preparation to sob. A tightening of the throat then intervenes, reducing or eliminating the stirrings of the sobbing.⁷

⁶C.f. Esther Bick's (1968) nice example of a six-month-old baby girl whose hyperaggressiveness had already taken the form of a "habit of pummelling people's faces." Bick metaphorically speaks of such body defenses as constituting a "second skin" -- i.e., as highly primitive defensive structures which ward off early "catastrophic anxieties in the unintegrated state".

⁷One might argue that what I have just called defensively distorted schemas could also be included under this category of countermobilization. And in a sense that is correct. For example, exaggeratedly used aggressive affectmotor schemas can

In other words a motor schema, elicited by circumstances, evokes movement X. A simultaneous or almost simultaneous countermobilization then evokes movement Y, which works in opposition to movement X.

An interesting aspect of countermobilizations is that most of them are so minute as to be invisible to the naked eye. For example, if you saw a small child struggling to hide a wave of sadness you might well see a large and obvious harding of the throat musculature, compressing of the lips, etc. A adult however will often use only an incipient, abbreviated form of these movements; so abbreviated that even if your eye is trained to catch those things you might miss it. In therapy a decent number of these movements will be discovered only through a kind of learning process whereby the patient develops the ability to sense them from inside.

That raises a nice theoretical question. Clearly for the small child the countermobilization is functioning in a quasi-mechanical fashion: throat-tightening, chest-locking, lip-compressing and the like work directly against the movements which would facilitate sobbing. But what about for the adult? Naturally for her too there may be occasions when she does it like the child. Faced with an overwhelming emotional situation she may well rigidify her chest and glue her lips together in an attempt to "push it all down". But what about her more everyday mini-countermobilizations, so to speak? It could well be that these are functioning in a highly different manner -- more as

effectively crowd out the emergence of other possible schemas. But clinically it is extremely helpful to distinguish between the defensively distorted schemas, with their states of increased affective arousal, and the more simple acts of muscular constriction which I am here calling countermobilization.

inner signals, as reminders, as a kind of motor warning system. Perhaps larger mechanical countermobilizations are evoked only when "signal countermobilizations" have been insufficient.⁸

Occasionally one sees more massive and global forms of the larger countermobilizations. For example, certain psychotics struggling against the onset of florid symptoms at times rigidify their whole bodies moments long. They might be resisting a hurricane which threatened to sweep them away. Usually, however, a countermobilization is confined to a specific muscle group.

4. *De-activation* is similar to countermobilization. Only it functions in the opposite fashion. With de-activation a neurological signal is sent to the relevant muscle group "telling" it to reduce, not increase its tonus.⁹ The muscles are told to go more limp, even though the actual decrease in tonus may be slight. In fact when the tonus change is quite minute -- and for adults that is typically the case -- we might well speak of "signal de-activation", just as I speculated above about "signal countermobilizations".

For example, one patient discovered, as he became better at sensing his body, that his arms and shoulder girdle often took on a peculiar subtle quality of lifelessness when he felt someone else's immediate presence as too close, too crowding. He experienced this at times with me too. Working with both cognitive and bodily associations we learned that this was an unconscious means

⁸I of course have in mind here a parallel with Freud's (1926) concept of "signal anxiety".

⁹C.f. Stern's (1977, p.118) comments on "going limp", one of the evasive actions taken by infants several months old when other avoidance mechanisms prove ineffective in the face of an intrusive caretaker. The infant globally inhibits his motility, and then passively stares straight ahead.

of sabotaging an incipient "muscular wish" to push someone away.

5. *Chronic holding* is somewhat like countermobilization. Only it is static; a quasi-permanent, habitual muscular state of affairs. Muscle group Y is tightened up in order to work against movement preparation X -- only Y stays there in place. For example, certain muscles of the jaw may remain in a condition of quasi-permanent tension in opposition to motor schemas which govern biting.

Most of the time we have no conscious awareness whatsoever of these holdings. They are there hard at work twenty-four hours a day. The brain is endlessly sending its command for the muscle to remain contracted, and the muscle is endlessly doing it. For all we notice, this activity might be taking place on another planet. Even as a person learns how to become more aware of his body these holdings are more difficult to discriminate than are, e.g., the comings and goings of countermobilizations and de-activations. Their static nature effectively keeps them more hidden.

In writings on psychotherapy, chronic muscular holding is the most well-known kind of body defense.¹⁰ When Reich for

¹⁰So-called "body reading" is also based mostly upon chronic holding. By looking at the overall pattern of muscular tensions -- the "body structure" -- the therapist makes judgements about corresponding personality traits of the patient (e.g., Lowen 1958; Kurtz & Prester 1976).

It is a questionable way to arrive at a diagnosis, in my opinion. I have seen many mistakes made by therapists who relied too uncritically upon systems of this kind. My strong preference is to make a diagnosis in a more traditional manner (evaluating symptoms, defenses, object relations, etc.). I do use attention to body structure in this more limited way: if there are clear discrepancies between my initial diagnosis and what some of the "body reading" systems would suggest, I then probe and evaluate my initial diagnosis still more thoroughly.

example in his later writings speaks of the *Panzer*, the armor, this is normally what he is talking about.¹¹ In fact many times when therapists refer to the concept of body defenses it turns out they mean this form alone.

Worth keeping in mind, however, is that it is just one type among others.¹² And its importance should not be overrated. I have seen this confirmed many times over by the following phenomenon. A person comes to me, or to someone being supervised by me, for therapy. Thanks to many years of having engaged himself in one or more body disciplines (yoga, Alexander techniques, Feldenkrais techniques, rolfing, etc.) this person has already successfully reduced his overall body tensions to a point such that he has quite a bit less chronic holding than the average person. Yet his psychological problems remain largely untouched, even when they happen to be severe ones. Say for example before taking up the body programs he was a malignant narcissistic personality. The likely state of affairs now is that he will be a looser, more relaxed, more supple malignant narcissistic personality. There can be exceptions of course, even the occasional miracle cure. But by and large the notion that a reduction of "body armor" is certain to have a deep psychological impact just

¹¹In his early psychoanalytic writings Reich (1949) also uses the term. At that time however he meant by it simply the sum of a person's most habitual psychological defenses -- i.e., "characterological" defenses.

¹²It perhaps should be added that muscular tightness in the body can have plenty of other causes. Not all of it represents a mode of defense, with respect either to origin or present function. A profession, a sport, a physical accident, an illness may leave evident traces in muscular organization. A potter will have a slight rotation in his spine -- i.e., the muscles will hold the spine a bit twisted -- from his years of working at the wheel.

doesn't stand up to the facts.

Why should that be? As I see it there are two good reasons. First, many key verbal issues have not been worked with. Second, even on the level of the body itself much of what needs to be re-organized has been left aside. Muscular holdings have been addressed; other types of body defense -- schema developmental arrests, countermobilizations, de-activations, and the like -- have not been addressed, or at least not sufficiently. The person has reached a point where he could spend the rest of his life becoming more "relaxed" without really further transforming the motor intersubjective field.

6. *Chronic hypotonus* is the opposite of chronic holding. An body area or specific muscle group remains in a habitual state of less than optimal tonus. Chronic hypotonus thus operates like a static equivalent of de-activation.

7. *Respiratory deadening* is perhaps the most potent of the body defenses. Its destructive effects are pervasive in the psychic economy of every one of us. It is a defense which borrows elements from all the other body defenses, putting them to use for a special purpose.

The sheer complexity of breathing has already been discussed (chapter 7). Remember, two intimately intertwined schema hierarchies are involved here. One has to do with motor functioning, the other with our patterns of awareness of our breathing. Remember also, that what is of most importance is not breath size but breath responsiveness. The metaphor of respiration as a sensory instrument, a form of "radar", is of help here. If (a) the breath itself functions with sufficient finesse, and (b) we

adequately maintain a marginal consciousness of it -- then it is capable of transmitting a great deal of information. We will receive much more data both about the nuances of our own inward state and about what we are perceiving in the other.

Hence the power of any defensive crippling of respiration. Our contact both with ourselves and with others is affected.

Unfortunately the same complexity which makes this psychophysiological system so potentially useful also renders it especially vulnerable to defensive distortions. I have already spoken about some of the critical factors involved in breathing - - e.g., its spatial distribution in the torso; its tempo, flexibility, and fluidity; the co-ordination of "upstairs" (thoracic) and "downstairs" (abdominal); the inhalation arc and the exhalation arc; the in-to-out transition and the out-to-in transition. Now, any one or all of these aspects can be defensively distorted. And with the aid of elements from any or all of the other forms of body defense.

Normally for example there exists a whole series of deficits in both the functional and the awareness schemas. Then in addition, superimposed upon that base of deficits, we find an elaborate network of breath-targeted countermobilizations, de-activations, chronic holdings, and the like. The three remaining types of body defense I am about to discuss also add their effects.

8. *Kinesthetic avoidance* is a general flight from the kinesthetic realm. This is a defense which affects how our conscious attention is distributed -- i.e., it influences how and when we choose to focus our awareness. One comes habitually to "tune out" the kinesthetic, to ignore it.

What I earlier called the motor, sensation and emotion

levels of consciousness are all affected thereby. The reduction of awareness is not complete, of course; no one could live in the world without some dipping of their consciousness into these levels. But through kinesthetic avoidance little beyond the minimum may be registered.

9. *Kinesthetic hyperconcentration* is a curious defense. And a rather less frequent one than kinesthetic avoidance. A particular aspect or area of the body is given extensive kinesthetic attention -- and the rest subjected to kinesthetic avoidance. The hyperconcentration is selective. A kind of island of the kinesthetic is separated out and given sustained, even obsessive conscious focus.

One version is represented by some dancers and athletes. That, I confess, was a great surprise to me when I first began practicing body psychotherapy. A dancer of considerable professional accomplishment, for example, proved to be on the whole highly out of touch with her body. Naturally when it came to sensing where to place limbs and torso in space she had a finesse at which one had to marvel. And a hyperattention to that particular dimension of body awareness was for her a constant concern, working or not working; it functioned almost like a drug. Yet she had very little contact with the nuances of her breathing. Little tolerance too for any build-up of body sensation not immediately connected with a directed movement. And little awareness of the ebb and flow of affect. At bottom her relation to her body had more to do with a fanaticism of mastery than with

any seeking of a deeper receptivity.¹³

Quite another version of this defense can be seen in patients who maintain an exaggerated attentive focus upon bodily discomforts and pains. Whatever is unpleasant in an immediate body experience is given a prominent place in the foreground of consciousness; the rest is largely banished. In its more extreme forms this version goes hand in hand with chronic psychosomatic conditions. The psychosomatic symptomology and the kinesthetic hyperconcentration mutually support each other.

10. *Visual body image constructs* are representations of the body which we use in order to reinforce a flight from the kinesthetic realm. They are an important supplement to kinesthetic avoidance.

These constructs represent the body as seen -- i.e., as seen from the outside. Often they vaguely manifest a viewpoint from a yard or two away. This is my body as someone else might look upon it. Or as I myself might find it in a mirror.

To possess such a construct obviously is not in itself a strategy of avoidance. The defense lies in what we do with it. This construct tends to become a kind of chess piece for our acts

¹³Bick (1968), Meltzer (1986) and Anzieu (1989, 1990) mention similar examples. Their helpful analyses are all quite close to the point of view I am developing here.

One difference should be pointed out. It concerns the question of the underlying purpose of such a defense.

Bick was convinced that its main function was to substitute for an inadequate sense that the body's boundaries can hold together and "contain" the self's inner content. Meltzer later followed Bick's lead on this point; and Anzieu, in his separate way, came to a like concept: the "*moi-peau*", the containing skin-ego.

I partly disagree. I would argue that the fear of a lack of containment in this sense is only one of the possible motivations for the formation of this type of body defense (and indeed for the formation of the other types). There can be other motivations.

of inwardly referring to body and self. To think about "my body" -- or about, in its bodily dimension, "my self" -- becomes to evoke this construct as the major referent. The problem however is that "my body" -- and, in its bodily dimension, "my self" -- could in fact have an a second, additional referent: namely the "lived body" as I phenomenologically experience it, a for the most part highly kinesthetic affair.

In other words, by means of too smooth a jump to the visual referent I slip over the existence of the kinesthetic referent. The image of an outer corporal shell becomes a convenient hook upon which I can hang my thinking of myself.

That hegemony only directly reinforces kinesthetic avoidance. It also helps us to deny how thoroughly we have fallen out of contact with ourselves. It masks the problem. It lets us think about our bodily being in a way which conceals how cut off from it, and out of touch with it, we really are.

Of interest in this regard are two classic psychoanalytic papers, one by Greenacre and one by Lacan. Both nicely see the issue here. In my opinion, however, both conceptualize it in too limited a fashion.

Phyllis Greenacre, whose writings in general contain many useful insights about the body, discussed a variation of this defense which she found to be playing an important unconscious role for fetishistic patients (Greenacre 1971). She accepts Freud's (1927) well-known "oedipal" explanation for fetishism: the fetish is magical denial, for the male patient, that women have no penis. But she adds what she thinks is an equally important, second explanation: one touching upon preodipal causes. For reasons having to do with dysfunctional early handling, the infant suffers from too much "primitive body disintegration

anxiety." As a defense against this anxiety he then learns exaggeratedly to accent visual images of his body and visual body-identifications with others. That denial of the kinesthetic, supported by the overtone visual body constructs, lays the groundwork for his later bizarre sexual symptomology.

Lacan's (1977) famous account of the "mirror stage" neatly takes the same idea a step farther. He proposes we should see in an infant's earliest excited dances before a mirror a paradigm of a certain basic defensive structure. What is being defended against is a fundamental fear of fragmentation: a reflection of the "organic insufficiency" and "motor unco-ordination" belonging to this period. (Lacan saw those fears as inevitable.) The visual construct -- an identification of the self with the mirror image -- serves so well because of its seeming completeness. In Lacan's wonderful phrase it offers a visual "orthopaedic" totality.

Greenacre's and Lacan's accounts both seem to me to capture the essential idea. Yet both their analyses require to be extended. Where in my view they fall short is in their conceptualization of what it is about the body against which the visual construct defends. Both here concentrate upon the primitive fear of fragmentation. Now I would agree that often this is a part of the story, especially with more seriously disturbed patients. But there exist other primitive body fears which can be equally important, equally strong; and sometimes stronger. And these other fears would seem just as much to be covered up by the visual construct.¹⁴

¹⁴Moreover the visual construct does not here function by itself. The primitive body fears are held at bay by a collaboration of different forms of body defense.

One, for example, is the primitive fear of insufficient bodily differentiation. What better support for a denial of that fear than the image of the outer bodily shell? There I see "myself", conveniently whole and unfragmented, as Lacan says -- but also supremely separate and differentiated from the other bodily shells. The other remains safely at point B and myself safely at point A. Nor is there any threat that the agency of the other might swamp my own. Likely the child's fascination as his own reflected image jumps and dances in the mirror has to do, partly, with a magical omnipotent control over this unthreateningly separate, passive other.¹⁵

Another is the primitive fear of bodily isolation. This is a fear which, when one sees it in a strong form in adult patients, usually goes hand and hand with markedly underdeveloped connection affectmotor schemas. Suppose we extrapolate backwards to the likely comparable situation for the infant. What better support for a denial of this fear than a mirror-image other who flawlessly matches every gesture, every movement? We have already seen (chapter 12) an important implication of Tronick's "still-face" experiments: that some infants lack a sense of being able to mobilize the other. What more perfect defensive fantasy than being able effortlessly to animate this totally responsive mirror partner?

As I have said, we know little of an exact nature about the

¹⁵Although in his analysis of the mirror stage he surprisingly fails to touch upon the issue of differentiation, elsewhere in his early writings Lacan tends to be extremely sensitive to it. In the object relations tradition the issue of differentiation doesn't really come into its own until Edith Jacobson in 1954 devoted a major article to it (Jacobson 1954). Lacan was already showing its importance in the early 30's (e.g., Lacan 1975).

origins of body defenses. When and how does the child first adopt them? We need additional information on this point, and a great deal of it.¹⁶

I will however hazard an impression. My guess is that body defenses are already being formed during the first life year. Obviously their precursors must be, at least in part, the earliest movement patterns used by the infant to avoid or break off dysfunctional contact (c.f. Stern 1977, pp. 109ff). (Possibly movement reactions developed in uterus represent still more primitive precursors.) Gradually these habitual body responses must take on increasingly more elaborate forms. At the same time they probably acquire additional layers of defensive purpose.

In any case, anyone who has worked with small children's bodies knows that, by ages three and four, plenty of unconscious chronic muscular tensions are already noticeable. I would argue that versions of all the other types of body defense can be found present too.

Perhaps a major turning point occurs during the second half of the second year? We know from unassailable evidence that in this period the infant finally becomes aware that the image he sees in the mirror is a reflection of the body he personally inhabits.¹⁷ He learns in short that he has an outside.

¹⁶Needed as well would be more precise definitions. C.f. Stern: "the line [i.e., the distinction] between an early coping mechanism and an early defensive operation is thin" (1977, p. 118).

¹⁷E.g., Amsterdam 1972, Lewis and Brooks-Gunn 1979. The classic experiment here is that the infant, without his realizing it, has a colored spot marked somewhere on his face. Then he is directed to look in the mirror. The question becomes whether or not he tries to touch the spot on his face with his hand, thus indicating he realizes that the spot on the mirror-face must be reflecting a spot on his own face. At around eighteen months most infants react by trying to touch the spot.

Unquestionably that for the first time creates a wholly new defensive possibility: the hegemonous visual body construct just described above. But it could be also that the defensive visual construct helps support, and in turn is supported by, a growing consolidation of other body defenses.

The idea that there exists a major turning point at around eighteen months is not new. (For a given infant of course it could take place a little earlier or later.) Mahler's rapprochement phase occurs at this time, for example. But if one brings together some different pieces of information from the current research, it becomes apparent that even more, and quite a bit more, is taking place. In one way or another everyone agrees that the infant undergoes a metamorphosis during this period. But the full amplitude of the transition has perhaps not been fully appreciated.

Stern (1985) and others, for example, have remarked that language at just this time is also taking on new dimensions for the infant.¹⁸ This is the period, for one thing, in which he first starts using strings of more than one word. It is also when he first begins referring to himself (and presumably thinking about himself too) with the first person pronoun (e.g., Lewis and Brooks-Gunn, 1979). Stern makes the criticism of Mahler, certainly warranted, that the emotional turmoil and moodiness one sees in infants at this time may well reflect much more than the simple separation anxiety which Mahler posits. Probably the infant is engaged in a painful passage from one universe to another, Stern suggests. She/he has been living in a largely

¹⁸Mahler of course mentions this but draws few conclusions from it. She never gives language learning the same theoretical attention as she does the rapprochement physical and affective behavior.

nonverbal world; and has largely been responded to, and has been able to respond back, through the nonverbal alone. Now that nonverbal universe must recede, slowly yielding much of its place to something else. The infant must learn to "understand" himself and to communicate with others by means of language.¹⁹

Yet there is still more. Emde and his colleagues (Emde, Johnson, & Esterboorks 1988; Emde and Buchsbaum 1990) conducted a longitudinal study of how and when families begin to confront infants with direct and explicit prohibitions -- "don't do that", etc. An impressive set of statistical facts emerged. Analysis of videotapes (taken in both the home and the laboratory) showed a massive crescendo of these messages cumulating at around infant age eighteen months. They found a clear inverted-U function in the data: with far fewer such exchanges taking place at twelve months, and again far fewer at twenty-four months, and with a "dramatic" (p. 50) concentration bunched together in the middle, at around eighteen months (Emde and Buchsbaum 1990). In addition, the infants themselves displayed an equivalent increase (and afterwards an equivalent decrease) in the number of times they seemed spontaneously to look to a parent for "do" or "don't" indications. Obviously we must acknowledge still further loss and alienation, beyond that which Stern has pointed out. The infant is also entering the world of prohibition and surveillance, and not just the world of language.

On top of this there is sex. And gender. Punishment for touching the genitals now usually begins, or if it has begun earlier, now increases. Additionally, the infant can now see the

¹⁹Lacan (1977) of course also has often proposed that the infant's "entry" into language represents a new alienation superimposed upon earlier preverbal forms of alienation.

genital region, both by looking down and by looking in the mirror. The realization is thus made that this body-which-can-be-seen-from-outside is a gendered body (Galenson & Roiphe 1974). Of course the training, so to speak, of movement and affect expression to fit social gender-related expectations, has begun long before this. Adults respond differently to what they perceive as boy or girl babies starting with the earliest months (Lloyd 1987). "Selective attunement," in Stern's sense, has already initiated the infant into the affect micropractices of a gender role.²⁰ But clearly at the eighteen month turning point, gender identification now acquires a whole new dimension.

In sum, it is especially in this period that the wider surrounding culture begins to enmesh the infant more tightly in its nets. Language, prohibition and surveillance, systemic social gender destinies, and the first demands to renounce sexuality: these now install themselves at the heart of the infant's lived existence.²¹ It therefore seems reasonable that this would elicit an answering strengthening of defenses, and particularly of body defenses. One could imagine a steady consolidation of the body defenses beginning early in the second year and

²⁰To what extent are gender differences in movement and affect expression innate? To what extent are they the product of social indoctrination? It seems to me we are a long ways from solid answers to this important question. Kestenberg (1975), for example, a psychoanalyst who has done some observational studies of infants and children, asserts that one can identify distinct gender differences in movement patterns, and that this represents an innate anlage. But the problem is that we don't know to what extent the observed patterns are wired-in, and to what extent they have been already created by the milieu through affective attunement, etc.

²¹Naturally there is much more to this transition than loss and alienation. The ability to use language and the ability to participate in a social community will also in the long run bring rich benefits. But the infant knows little of that.

continuing into the third year. Along with, very possibly, a corresponding firming up of the purely psychological defenses.

Probably we should think of this consolidation of body defenses as necessary on two levels. First, body defenses can help suppress particular affects and activation states. Perhaps an infant who has just learned to walk receives nonverbal messages (subtle or not so subtle) from a caretaker that she/he, the infant, should not roam far in physical distance from the caretaker's immediate orbit; and perhaps these messages become all the stronger the more the infant is displaying signs of exploratory excitement. A slight tightening of the feet and toes, as a countermobilization, might come to be developed as a body defense.²² The infant feels an adventurous urge to run, to dart off; muscle groups in the feet and toes contract; the urge is overcome. Specific body defenses, in other words, can have specific affects and/or memories and/or cognitive themes as their "target".

Secondly, the body defenses on a collective basis likely make a more basic general contribution. Operating as a group they must provide a kind of global, overall assistance to repression as a whole. A much-defended body allows repression an easier terrain, so to speak.

I must add right away, however, that the body defenses continue to evolve throughout childhood. Even if there is a consolidation during years two and three, that is not the end of the story. Sometimes the later developments can in fact be massive and dramatic ones. To take two rather tragic examples,

²²The example is based upon work with adult clients.

often sexual abuse suffered late in childhood will leave a residue of strongly intensified body defenses. As frequently will, in either a child or a young adult, an initial onset of florid psychotic symptoms. The body becomes a battleground whenever we feel taken emotionally beyond our limits. Additionally, during adolescence new affectmotor schemas embodying sexuality become available. As with other affectmotor schemas, it is entirely open, for any given individual, to what extent these schemas develop, and in what manner.

Nor should we ignore another complicating factor. As a child grows older it is no longer the immediate family alone which affects his relationship to his body. Other institutions together with more widespread social practices take on an increasingly powerful role.

For example, during infancy the child has already learned, to a greater or lesser degree, to privilege the visual construct in organizing his thinking about his bodily self. But a new step in later childhood and adulthood is that this "outer shell" representation will become a focus for practices of control and mastery, of shaping and perfecting. Dieting, exercising and other such regulatory activities then easily take on proportions having little to do with objective health. The postures and movement qualities of a particular social subgroup also are embraced more fully. One submits, again of course to a greater or lesser degree, to the endless quest of making bodily form and movement and appearance fit with current cultural norms.

In this respect we might speak of the *norm-dominated body*. As Foucault (1977, 1988) observed, these norms, whatever their other vices and virtues, effectively function as pervasive and extremely subtle mechanisms of social control. One could say

they blanket an individual with added reinforcements for his original constellation of body defenses. Bourdieu (1990) has shown examples of how body directives, and the practices which reflect them, can be intimately woven into the culture of primitive tribes. Bordo (1993) has superbly analyzed the more sophisticated versions of these modes of social regulation in modern societies.

It seems to be a constant in contemporary consumer capitalism, for example, that we are bombarded by messages which foster obsessive ideals for the body's shape and look. What shape, what look, will change over the years; currently the "slender hard body" (Bordo 1993) is much in vogue. But more important than the shifting nature of the ideal is the fact that it so haunts our relation to our bodies. Not everyone diets; not everyone exercises to an extreme. That is not the point. What is almost universal is how everyone internalizes the tyrannical standard. This not only fosters judgements of inadequacy (which also is not my point here); it additionally strengthens the inner authority of the visual construct. These norms serve in short as a kind of insurance on a social level that body defenses once formed in childhood will continue to maintain their constricting power.

Gender roles of course dictate differences in experience. Obviously there is a sense in which the norm-dominated body is more a source of conscious anguish for women than for men. The social pressure to conform to the current ideal is more pervasive; and more vicious, one is tempted to say. As Bordo (1993), Chernin (1981) and others have argued, this neatly functions to maintain systemic gender relations of dominance and subordination, whatever its other consequences.

Yet that does not mean there is no equivalent grip of body

norms upon men. First, obsessiveness about perfecting and mastering the body in its physical appearance is readily found among men; though not as extensively as among women, and seldom with the same self-torturing quality. (Were that not so, we would find a higher percentage of eating disorders among men.) Second, men, on the average, have learned to distance themselves more from sensation and feeling in the body than have women. They have internalized still more stringent norms about experiencing the body: a man "ought" to feel the body's force, not its weakness; its pleasures, not its sadnesses; its efficiency, not its poetry; etc.. Comparatively speaking, women are more prey to the defense of the visual construct, men to the defense of kinesthetic avoidance. Both genders make plenty of use of both defenses, however. Everyone in his way submits to the norm-dominated body, and everyone pays the price.

One last point. So far, mainly, I have only described the body defenses themselves. Next to nothing has been said about a related question. What lies under these defenses? What in us do they contain, reduce, suppress, constrict?

This is a more complicated question than it might in fact appear. It can be posed at different levels of discourse.

First, one can interrogate the clinical experience of body psychotherapy with regard to specific events and occurrences. What happens, within a given session, when there is a diminishing of one or more body defenses? With the defense out of the way, or with at least its suppressive effects temporarily lessened, what emerges? What makes its way to the surface?

About this we have already seen examples, and there will be a number of other examples in the next two chapters. (I take up

there work with body regressive states.) Body defenses appear to help to suppress unwanted affects; painful memories; forbidden wishes; threatening modes of contact with other persons; and undesired qualities of bodily excitement and activation. (I say "unwanted" and "undesired", but naturally on another level these same feelings are wanted and desired. Hence the underlying conflict.) Additionally, they help prevent change in a person's repertoire of affectmotor schemas. They keep schemas which have been held back or distorted in their early development from resuming their blocked growth. (This last point in particular will become more apparent in the next chapters.)

But the question can also be posed on a different level entirely. Does there exist a more primordial, a more basic something, which pushes for freedom from these defenses? After we have listed everything described above, suppressed feelings, wishes, etc., are we forced theoretically to speak as well about some still more underlying phenomenon?

This is certainly an issue which can be raised. But in my opinion it is one concerning which we need to be highly suspicious of easy answers. A traditional temptation, of course, has been to speak about an inner core, or esoteric energies, or some other form of presumed "natural body" waiting to be freed from the inhibiting cultural crust of body defenses. This is a form of answer which tends to create confusions rather than dispel them, however. Usually it revolves around a simplistic nature/culture opposition which is difficult to defend and which has little to recommend it. (A typical example is Reich's theory of body "energy", a detailed critique of which I give in chapter 20.)

The reality is that a model of body psychotherapy such as I

am presenting does not need to commit itself to one or another particular response to this wider question.²³ And in this book I will not try to do so. To repeat, I am not against the question itself. I just see it as belonging to a different order of inquiry, and also as distant from the day-to-day concerns of doing therapy.

Let me take care not to leave a mistaken impression about one aspect of this matter, however. I do not mean to imply that anyone who confronts these wider issues should forget about or should marginalize the biological body. That would be an oversimplification of another sort, in my view. What I want to say is merely that the relation between what is biologically wired-in and what is culturally added appears to be extremely complex.

For example, I have so far made the following proposals.

(1) There are elemental forms of many affectmotor schemas which are probably innate. (2) In infancy these schemas tend to evolve, to grow in complexity. (3) Dysfunctional infant-family interactions can inhibit and/or distort this evolution. I will also in the next chapters amplify the point that (4) psychotherapeutic work with the body often can effectively create the conditions whereby these schemas, where needed, can resume their blocked growth. But does this mean that the "right" or "healthy" growth of these schemas is a *natural*, i.e. a non-cultural, affair?

Not in the least. To begin with, it is presumptuous of us even to say that one potential growth direction is healthy and another pathological. A psychotherapist cannot escape that presumption. But, aware that such judgments nowhere rest on sure

²³Gentis (1980) in an eloquent discussion has also pointed this out.

premises, she or he can at least be restrained about making them.

More important is the interplay of the biological and the cultural in the very shaping of the affectmotor schemas. How are we to say where the one ends and the other begins? From the very beginning the interactional styles of the primary caregivers are sculpting how the infant feels and expresses affect. And the infant certainly seems to seek out this shaping influence. So what do we call this wired-in mutual dance? A biological grasping for the cultural? In any case the interweaving is so intricate that we are dealing almost instantly with a kind of amalgam.²⁴

Finally, after infancy the destiny of any given affectmotor schema continues to remain highly indeterminate. As I see it, these impulses do have an inherent impulse towards growth and development, but the specific direction of this impulse is not fixed the way an acorn is designed to grow into an oak. We should think of an "impulse towards...X", where (a) X is highly open to choice and selection, and (b) of necessity X must avail itself of cultural instruments.

Just as to speak requires a language, so with emotion. We depend upon a cultural framework of learned expressive movement, and of learned modes of uncovering emotional meaning, which is only partially anchored in biological givens. This framework is not a second language; it is its own mode of encountering the world, analogous the listening to music. How any given client will want newly to insert himself or herself into its possibilities cannot be said ahead of time. This is for himself/herself,

²⁴For an excellent discussion of many other respects in which neat and easy distinctions between the biological and the cultural tend to break down upon close analysis see Grosz (1994).

the client, to discover. The job of the therapist is simply to help create the conditions for that discovery.

Ideally, of course, that will include an attention to the client's body defenses. A therapist who works verbally alone can in a limited way do this; can and should. A body psychotherapist will do so with the help of physical techniques also. Either way, the more the patient can explore these defenses -- gradually modifying them, gradually lessening their rigidities --, the better. It greatly heightens the potential for personal change.

Chapter 17

THE ROLE OF REGRESSION

'Regression' is another much used term which has come to mean too many things.

Sometimes it carries a negative tone. A particular psychotic patient, a colleague may say, is currently in a "regressed state" -- meaning that he/she is bad off, his most debilitating symptoms are coming back, he has lost part of his ability to function. This is at times also called "malignant" regression.¹

It is a notion which rests upon a rather dubious assumption: that the more dramatic dysfunctional conditions of severely disturbed patients represent a defensive return to early infantile modes of being in the world. Personally I don't think this idea has stood very well the test of time. For example, a decompensating borderline patient who has begun to manifest psychotic symptoms is said to be retreating to forms of psychic organization belonging to his early infancy. But the more seriously

¹After Balint (1968). His original sense of this term was more narrow: he meant a regressive condition in the transference in which the patient becomes endlessly demanding.

one takes the new infant development research, the weaker this equation appears. The clinical profile of a highly disturbed patient in a severe condition has little in common with the interactional competencies seen during even the earliest months of normal infancy.² This use of the term is widespread, however, so probably we will simply have to live with it.

A second common meaning I find more useful. We may speak of periods when in some way the patient is allowing the atmosphere of his childhood to re-emerge in the therapy. Who, himself or herself a patient in therapy, has not sooner or later experienced "waiting room" jealousy? You have arrived well ahead of the hour. You sit down to let the minutes pass. The office door opens, another client walks out...and to your acute embarrassment you suddenly find yourself furious. Like an out-of-control five year old, you are incensed someone else is sharing "your" therapist. Excellent grist for the mill.

Regression in this sense is a sign the transference relationship is deepening. In the example above, the patient likely is moving towards a new phase of the therapy. To differentiate it from the previous meaning this is sometimes called "benign" regression.³ Its appearance, assuming skillful responses on the side of the therapist, will introduce an important and valuable new treatment dimension.

It is however a third form I wish to discuss here in more detail. Productive for the therapy, it is a positive version; but of a particular sort. Basically it is a passing state which can easily occur when one works with the body. A piece of child-

²For another criticism of this notion of regression see Heimann (1989, p. 335).

³Again after Balint (1968).

hood comes to the foreground of the patient's consciousness with a special bodily force.

This experience can last some minutes. I refer to it as a "body regressive state" or simply a "body regression". It is more immediate than the usual therapeutic encounter with memories. The patient for moments half feels as if he were "right there", as if the past events were unfolding here and now. He knows this is not true, much like someone who watching a movie knows it is just a movie. Yet he feels his body engaged. The entire experience has an uncanny somatic vividness.

It is not impossible for a patient who is working in a verbal mode alone to enter into an experience like this. That can happen in any type of therapy, and especially in psychoanalysis conducted with a client lying on a couch. But it then happens more seldom, and it is also rare for the same bodily intensity to be present.

In principle, assuming the patient is ready (see below) to tolerate the attendant feelings, this state is highly positive for the therapy.⁴ For seconds or minutes a unique window has opened. An opportunity is present. Child and adult simultaneously, the patient is positioned to let re-form an inner "something" which insistently seeks metamorphosis.

How best to take advantage of this unique opportunity? Here there is much for a therapist to learn and master. Therapeutic work with body regressions is at times quite complex. I will go

⁴Hartmann (1958) was fond of speaking of "regression in the service of the ego". What I am calling body regression can be understood in those terms, in that a strong push towards working through old conflicts seems inherent in the experience. But the distinctiveness of body regression also should be recognized.

over several central points.⁵

The opening moments.

The first manifestations of a body regression are often subdued and indistinct. The patient becomes aware that "something is happening", but the experience seems unfocused and vague. Normally a therapist accustomed to working with these conditions will recognize the onset, however. He/she will have developed an intuitive feel for it.

Frequently too there are some obvious clues. A client for example may report feeling "small", or "like a little child". Or the onset may announce itself by a peculiar constellation of somatic experiential phenomena. "I am very aware of my mouth. It is becoming huge. Very curious." Or, "my arms are becoming weak, almost as if they aren't there." Or, "my body from my chest downward is getting smaller." These are not delusional ravings; once understood, they show an impeccable logic. The patient in this instance is simply regressing, for a moment, to the body organization of earliest infancy. A small baby is indeed mostly mouth, eyes, and neck, those being the areas possessing substantial motor control.

At other times, however, the first clues are less easy to read. A patient in one session started to feel a sharp sensation, mildly uncomfortable, in her left temple; and slightly faint. Only after several minutes of more exploration did I realize that "something" of a regressive nature was beginning to

⁵Naturally the more minute technical details need to be transmitted through training and supervision.

emerge. And only a little later still did it become clear that we were dealing with the residue of a childhood accident involving a massive blow to the head.

As soon as the therapist recognizes the early signs of an regressive experience he then faces a choice -- perhaps the most critical of all. Shall the regressive state be entered into? Shall the door be opened?

That decision must rest squarely upon a judgement about where the patient currently stands in his therapy. Three aspects especially must be taken into account. (Normally the therapist now is thinking to himself. He can decide afterwards whether or not to share any of his reflections.) First, how well can this patient tolerate the emergence of affect? Second, how ready does he seem, generally speaking, for what sometimes turn out to be painful truths about his past? Third, how solid is the current working alliance between therapist and patient?

Standing behind those questions is, from my point of view, a more fundamental conviction about the overall role of work with regressive states. It might be summarized so: there is no rush. I have already reviewed (chapter 4) how the therapist should think through a somewhat different decision: the determining when, in the therapy, to begin with direct work with the body in general. The choice being discussed here -- whether or not to help the patient enter into an emerging regressive experience -- raises similar considerations.

This is because for many patients the right place for regressive work is later in the therapy, not earlier. A solid base must first be laid. That means, for one thing, extensive verbal investigation of the transference. For another, it may well mean a long period of more delicate work with the body: work which

focuses on sensations, and which here and there takes up emotions too, but which stops short of a more thorough exploration of regressive experiences. Especially with more disturbed clients this caution pays off handsomely over the longer run.

As a consequence, it frequently happens that the therapist judges now is not the time. The conditions which would insure a productive use of a regressive state are not yet in place. In that case the therapist intervenes so as to move the patient away from the emerging experience. This is easily enough done; one just stops with the work with the body.⁶ If necessary the therapist briefly explains why he is suggesting to break off the flow of the experience.

A transition is then made back to a purely verbal exchange. This transition can be brisk or quite gradual, depending upon what seems to fit. Frequently, however, the therapist does not even need directly to propose, explicitly, that the door be shut upon the regressive experience. The transition comes about rather because of what he doesn't say: i.e., because he doesn't intervene with any guiding suggestions (see below) about how the patient might increase his contact with the emerging experience.

⁶There is an important exception, however. A tiny minority of psychotic and borderline patients while working with the body can drop into a regressive state which almost instantaneously becomes very intense. For that situation I have developed a set of special techniques which bring about a fast restoration of a calmer state. Similar techniques are then subsequently used to help the client build up better skills at managing "unwanted" affective conditions outside the therapy setting.

In general I find the psychoeducation approach of Falloon (Falloon et. al. 1984) and Anderson (Anderson et. al. 1986) to be an extremely helpful adjunct to the treatment of schizophrenic patients. The special physical techniques to which I am here referring extend the psychoeducation concept to the domain of the patient's relationship to his body.

Should a more explicit closing of the door be necessary, then often a change of physical position helps. A patient who was lying or standing is asked to sit. A patient who was already sitting is asked to find a new sitting posture, one which alters his immediate state.

The elements of the network.

Suppose however the decision is to continue. In that case the initial technical steps are as follows. The therapist encourages the patient to maintain his awareness of what is going on in his body, and to try to allow this "what is going on" to develop further. On his/her side the therapist now attempts to observe every tiniest body change -- movements, breathing, changes in tissue tonus, changes in skin coloration, flickers of facial expression, wetness or dryness of the eyes, pupil dilation or contraction, etc. At the same time the therapist intervenes fairly often with experiential interventions. (Typically. There are exceptions. Sometimes, when the regressive state is unfolding quite organically without external help, one senses that interventions would be intrusive.)

Why so strong an emphasis upon experiential interventions right now? Because of a particular difficulty. A regressive state at this early point tends to be rather diffuse. Often it is a kind of jumble of fleeting impressions. Several body sensations, an obscure image, a hint of a feeling mood -- it is clear to the patient that something is "coming up", that something "wants" to make itself felt; but the connecting logic of the

emerging pieces is not yet apparent.

For this seeming absence of a connecting logic there is a very good reason. It is that the emerging memory itself consists of a certain number of discrete subparts or constitutive elements. And these elements correspond to aspects of the original experience which were lived and sensed on the different levels of consciousness (chapter 5). The original blow to the upper left ribs as the car crashed is now, in the regressive state, felt as a twinge or tightening or pain in that area -- i.e., it comes up as an element on the sensation level of consciousness. The sight of the car's upholstery, the first thing seen afterwards back then, emerges now as a confusing patch of brown color. Often these disparate emerging elements seem at first to make no sense because their context has not yet been established. Collectively they make up an "associative network", to use the very helpful concept of Peter Lang (1978, 1979, 1984; Lang et. al. 1980). But what the package as a whole represents will not become clear until enough of the network has become conscious. Hence the need of experiential interventions. Judiciously timed, they will help one after another of these dispersed elements to swim into focus.

Usually the best strategy with these interventions is to *shift about frequently from one to another of the levels of consciousness*. Now a question is posed about what the patient is in touch with on an image level; and now about sensations; and now about what thoughts are going through him; etc. One should aid the patient to keep scanning all of the levels. That, to him, is likely in this moment a not so obvious task; nevertheless it is a crucial task. The more all five levels can be brought into awareness, the higher the probability that the disparate elements of the emerging state can be brought together and under-

stood. Here is truly one of the keys to appropriate work with regressive states.

The meaning of the network.

Before going any farther it would be good to review a couple of distinctions discussed previously (chapter 9). They concern the meaning and content of the emerging network.

First, you will remember that what comes up from the past might be either (a) a primitive object relations unit (in Kernberg's sense, c.f. chapter 9) or (b) the representation of a single traumatic event such as, e.g., a physical accident, a medical operation, a death of someone near.

An object relations unit is a representation of a former interactional pattern from the patient's past. It is a generalization of one strand of the former relationship between client and mother, or client and grandfather, etc; or even between client and some wider family system or subsystem. It is a representation, in other words, of interactional sequences which formally took place hundreds or thousands of times. Most regressive states consist of (a) a slow, circuitous coming to consciousness of this type of representation, and (b) a continuing attempt to work through some of its unresolved aspects.

A seeming exception, frequently encountered, is a network of associations representing a one-time event: an accident or the like. As I mentioned before, however, the "one-time" nature of such a registered event is often illusory (chapter 9). What made the event so intensely traumatic, and what made an inward resolu-

tion so difficult afterwards, may have been some background of object relations. For the eight-year-old child the witnessing of her grandmother's death was terrible; but equally oppressive was the tyrannical family silence about the event during the months afterwards. She could speak to no one about her upset and loss, there was no chance for her to come to a normal inward resolution. Thus what at first seems like a single frightful event may turn out to have everything to do with one or more old object relations patterns.

The temporal reference of the network.

A second distinction concerns the time period of the past. The associative network which is emerging might have to do with any former era of the patient's history. This even includes the adult past. A trauma which took place only a year ago might turn out to be the content.

However, sometimes what shows up appears to belong to the preoedipal past. These types of memory appear to be different in their intrinsic structure. I have called them "kinograms" because they are simultaneously so somatic and so little verbal in nature (chapter 9). In other words, as the discrete elements come into focus they belong predominantly to the motor, sensation, and emotion levels of consciousness. Visual elements may emerge too, but these tend to be diffuse and vague. Verbal elements are absent almost entirely.

Most of the time it is not so difficult to determine what is probably a kinogram and what is probably a memory from a later

time. The more the regressive state unfolds, the better one can evaluate. If the memory is from an era later than the preoedipal, then a series of verbalized thought-elements is likely eventually to emerge. To return to an above example, first comes up, let us say, a hurting in the ribs and the floating patch of brown color. Then additional sensory elements emerge; they make the patient gradually aware that the network has to do with a former car crash. And then at some point a flood of verbalized thought-elements also shows up: "the car is wrecked...I'm hurt...am I dead or not...where is X, my friend who was driving...", etc. These are likely, we can assume, not just a commentary being added now but a partial reproduction of thoughts which actually occurred in some form back then.

A kinogram, on the other hand, even as it unfolds, continues to lack this dimension of words and thoughts. Of course the therapist at various points will encourage the patient to try to find language for what he is experiencing. But this is rather a translation, a putting into words of something which originally feels beyond words; and usually it requires the therapist's assistance.

Clarifying the self and object poles.

So, during work with a regressive state, the first technical challenge is to bring the gradually emerging representation more into focus. This can require a little time. As the patient feels his way into the experience he must gather data, so to speak. That cannot be done hastily.

Essential to accomplish next is to clarify both the self and the object poles of the crystallizing experience. Often it is only the self pole which is felt at first -- "I feel myself as small," etc.. But the other pole will always be there, latently. In order that it take on more definition the therapist may need to draw the patient's attention in that direction. "What do you feel happening?" "What do you feel outside you?" "What seems to be happening around you?" "What are you feeling sad/cozy/threatened/irritated about?" "Where is it, this 'something' which is threatening/comforting/annoying you?" "What is it like, this 'something'?" Interventions (there of course exist many more) along these lines will now be helpful. They are experiential interventions, but ones which specifically steer the patient towards the object pole. Of course they can be followed up by interventions emphasizing the subject pole: e.g., "And right at this moment how do you feel that sense of intrusion in your body?" Frequent swings back and forth between the two poles aid the most at this point. The patient is encouraged to search out the specific nuances, the fine details. The more of these discriminations he can make, the better.

This bringing of the object pole more into focus is especially important whenever a kinogram appears to be in play. In that case one cannot expect the same degree of detailed clarity. But usually certain global key aspects of the combined self-and-object representation can be brought more into awareness. One patient began twisting her head from side to side with fury and desperation. Through experiential interventions I helped her notice whatever she could about her sense of the outer situation. As she responded to her own movements and to some diffuse visual images, her growing sense was that a huge face was darting back

and forth and chasing her, like an airplane or a giant insect. We had already in the therapy worked extensively with later memories of her mother's intrusiveness. But this and some similar regressive experiences allowed us to confront what certainly appeared to be a much earlier stratum of memories. It gave us the chance also (how this takes place will be discussed shortly below) to work with some differentiation affectmotor schemas (c.f. chapter 11), ones which for her had apparently undergone too little developmental refinement.

Of course once in a while the representative network has no "object" in the sense of another person. The memory may be of a simple traumatic event which happened to the patient when he was alone. All the same, while working with the regressive experience, the patient must define the ambiance around him, the exterior setting where the event takes place. In that case the "object" pole is just the setting itself, and especially whatever in it or about it most impacts upon him -- e.g., the trunk of the tree which, as he is flung from his horse, his shoulder strikes.

Any affective quality already present in the experience also needs at this point to be defined. Early in a regressive state the strength of its accompanying affects often will be quite minimal (unlike the example just given, where the patient felt instantly upset). But usually there will be enough emotional tone that the patient can at least sense it and put it into words. Later, of course, if work with the state continues, some intensification of these affects is likely to occur.

The initial motor impulses.

A critical separate task (though in practice it will frequently overlap with the others) is to define the initial motor impulses and motor adaptations. These are immediate motoric responses to the object relations or external situation. They are what the client's body first appears to "want" to do in reaction.

Usually the initial motor impulses are not the only motor impulses, however. Others (I will give examples shortly) may well unfold a little later. These initial impulses will tend to be rather those which the patient finds most "natural". This means, of course, not at all that they are truly natural; but simply that they are the ones which belong to his habitual response repertoire. Sometimes he will even begin quite early to manifest one or more of them in actual movement, at least in an abbreviated form.

For example, he may have defined the outside pole as a threat of invasiveness. Perhaps as well he has a sense of a large surrounding "other's" body which impinges upon him, slowly but massively, restricting his movements and interfering with his breathing. Next, with a little more awareness of the self pole, he may discover that his initial motor reactions consist of a tendency to inflate his chest, and to stiffen it there in the inspiratory position. He may actually have just now stiffened it in this manner, or he may only be in touch with an urge to do so.

If, as he speaks about his experience, the patient has not already mentioned initial movement impulses, the therapist must make sure to ask about them. Almost always they are easy enough

for the patient to perceive. The therapist can also indicate what he observes, in the event that the patient fails to talk about some small movement which clearly already is in play. "I notice too you seem to be moving your jaw the least little bit up and down. What is that like?"

Why it is important to define these initial impulses in words will become apparent a little later on. But you can already see one aspect. They often give us, these first-appearing motor tendencies, some valuable hints about the underlying status and condition of certain affectmotor schemas (c.f. chapter 11). Especially this is so when such responsive patterns emerge with some consistency in the therapy. In the example just given, we can notice a distortedly developed schema (the inspiratory stiffening) being used as a body defense. One would almost certainly find as well some unavailability of differentiation schemas. Further exploration of the regressive state would be necessary in order to pinpoint exactly which ones, and to what degree they are unavailable.

The example above was of a kinogram (indicated right from the start by the patient's sense of a "small body" self in interaction with a "large body" other.) Memories from later childhood periods, however, when they surface during a body regressive state, will also frequently give clues about the underlying status of various affectmotor schemas. For example, during a body regression a woman came in touch with memories of her relationship to a slightly younger sister during their adolescent years. Due to both family coalitions and separate sets of school friends they had grown quite apart. A strong affect of longing for more contact with this sister then emerged as the regressive state developed. However, her only motor impulse initially was

to go limp, into a kind of global passivity.

This was a response we had seen plenty of other times working with her body. It was not specific to her relation to her sister. Underlying it was considerable impoverishment of a number of her connectedness affectmotor schemas (c.f. chapter 12). That state of affairs had a great deal to do, historically speaking, with very early preoedipal interactional experiences. But, needless to say, the same pattern continued to exert an influence during later childhood periods. They had become a part of her interpersonal "stage-setting."

The cycles of activation.

There are a number of further steps. But before we pass on to them I must mention an additional possible complicating factor. This factor can sometimes be present from the first onset of a regressive state.

What can happen is this. The state as it unfolds may be accompanied by marked fluctuations in the patient's overall degree of bodily activation. One may first see a sudden pick-up in affective tone, and/or little movements, and/or signs of autonomic nervous system activity (e.g., pupils widening, increased heart beat rate, etc.) After one or several minutes, however, the arousal may drop off again. In fact it may well drop even below the overall degree of activation which was present just before the onset of the regressive state.

Then there occurs a kind of pause, like an intermission. But next, after a minute or two (sometimes more, but also some-

times even less), the patient is ready to go on. His arousal then climbs again; and the regressive experience unfolds a little further. And so it continues with further cycles: mounting, decrease, lull; mounting, decrease, lull. Should the process develop so, it will be highly puzzling to the therapist if he does not understand what these cycles are about.

This can go on even during these first therapeutic tasks described so far. While taking those beginning steps (defining the object pole, the subject pole, his initial motor responses, etc.) a patient will sometimes pass through several such cycles of physiological activation.

Perhaps not, however. Sometimes at the beginning of a regressive experience the body will at once display an increased global agitation. And then it will simply stay at that higher level. Or, in another frequent pattern, the overall arousal may increase gradually, in a slow steady rising line, with no dips or pauses.

But at other times the physiological activation will repeatedly mount and descend. This will be a little more complicated for the therapist. It will create a kind of "on and off" quality to the experience, a quality which the therapist must be careful not to misunderstand. The client is not avoiding anything, or being incongruent. He is merely following the activation curve wherever it leads him.

Sometimes, in this form of regressive state, the arousal cycles peak out early and low in the beginning. And then, gradually, they peak out at progressively higher levels. One cannot say, clean and neat, that every time the peak is higher; that varies. But the general tendency, if the patient is willing and

able to continue, is towards a gradual heightening of the peaks.⁷

The right technical response to these cycles is for the therapist fully to accept them. Indeed to welcome them. They appear to have a highly beneficial function. Effectively they serve as a kind of built-in safety factor, allowing the patient to gather his forces before going further.

They also introduce many potential breaking-off points. In one of these moments of rest -- between cycles, so to speak -- a patient may well decide he has pursued as much as he wishes, for that particular day. This of course is no problem. What is not worked though in a session today will return again during regressive experiences in later sessions.⁸

(*The alternative motor impulses.*

Next comes perhaps the most important step of all. The core of successful work with regressive states lies in the execution of what follows now. The client must be helped to define and to explore one or more alternative motor impulses. I will explain.

⁷Levine (1992) has an excellent discussion of this point. Levine has developed a combination of hypnosis and delicate body work. His cautious approach to regressive states, an approach thoroughly free of cathartic models, I find exemplary.

⁸This is a reliable general truth, I find. But there is an important exception, one concerning countertransference. Sometimes the content of the emerging regressive material will unconsciously be too threatening to the therapist. He may then send covert signals which have the effect that the patient avoids this content area in the future. What Langs (1977) calls a "bastion", an unconscious collusion to stay away from certain themes, will thereby be created (c.f. chapter 23). Doing supervision I have come across this situation a good number of times.

To start with, the therapist must evaluate the nature of the initial motor impulse -- the first response to the object relations situation, that first reaction already reported or displayed by the patient. The question is whether this is intrinsically a productive or counterproductive response -- because frequently it is a counterproductive one. That is, what may have been originally, in infancy or childhood, a necessary defense -- e.g., in the example above, the rigidifying of the chest in an inflated, pushed-out position -- is today, in adulthood, a counterproductive affectmotor habit. In other words, the therapist at this point is trying to determine which affectmotor schemas have been brought into play; and whether they represent, as often is the case, defensively distorted motor schemas (c.f. chapter 16).

Along with that evaluation comes a second one. The therapist must also try from the beginning to estimate what affectmotor schemas are *missing*; either missing entirely from the client's perception, or only weakly noted by him. This is of course to look from the point of view of optimal functioning. If the schema (or schemas) the patient has so far activated are counterproductive, then what, given the portrayed scenario from the past, might be the productive schemas which evidently are unavailable? What, bodily speaking, should he have been able to do but apparently could not?⁹

The essential idea now is to aid the patient with a step towards allowing one or more of the undeveloped schemas to take

⁹Of course it can happen that there is no need to scan and probe for alternative motor responses. The initial reaction itself may be a productive one. Then there are two choices. Perhaps one just works further with that reaction. Or it may be profitable to search out and explore some less developed productive alternative.

on more shape. In practice that is less difficult than it might sound, thanks to a fortunate reality. This is that major undeveloped affectmotor schemas patently "want" to manifest themselves and to grow. It is an extremely reliable clinical principle. They have a remarkable intactness, these frozen schemas, as I have already mentioned previously. Even when their development has been negligible and the defenses against them massive, they retain an essential integrity. And along with that they possess a strong "self-uprighting" tendency. Moreover, it is during the unique conditions of a body regressive state that this self-uprighting, this "want to grow" quality seems most easily contacted. In ways we do not yet fully understand, a body regressive state must permit a heightened access to normally split-off, arrested affectmotor schemas.¹⁰

How to bring about this shift to a focus upon the productive schemas? Several modes of intervention are here possible.

One is to encourage the patient to scan within and try to find at least the barest beginnings of any alternative response with his body. Once he can locate at least the nub of an impulse, what comes next is simple. He needs only to follow the impulse, to bodily explore it; to feel out its direction and to experiment with bringing it into a fuller motor form.

Take our same example of the patient who, protecting himself against intrusion, initially stiffens his chest. Looking more

¹⁰Sometimes too a simpler movement needs to take place, a movement which in a former traumatic situation was begun but then interrupted. These are usually movements of orientation and/or protection. Struck in the back of the head by a swing, the child's first reactions were to duck as well as to turn around and look. He fainted; these movements could not be completed. They may re-emerge as impulses in the regressive experience. In that case the therapist should allow them now to complete themselves (c.f. Levine 1992).

carefully for other response alternatives he might find that his arms "want to do something." Tracking the impulse he might then discover a motor wish to push. Then there are two options. One, that he just imagine pushing. He can explore this motoric fantasy up to the point where he wants to stop. The other option is that he actually push into the air, trying out different rhythms and movements -- e.g., slowly inching the arms a little forward as if moving a great weight, snapping the arms out hard and fast, etc. Normally he will come across one way of doing it which "clicks"; this way will have a strong emotional resonance, a rightness, to him. He can then experiment with further variations of this "right" movement. Often it will be rather tentative and vague in the beginning. Repeated variations will let it take on more defined contours.

Another type of intervention can be based upon the therapist's observation of the patient's nonverbal movement. The therapist may notice some part of the patient's body starting to move; some part which the patient himself seems not to have remarked. Calling attention to this incipient movement, the therapist can suggest that the patient feel out whether an alternative response is here ready to take shape.

Yet another possibility is that the therapist propose a particular movement. The suggestion might be, deliberately, rather open: e.g., "you might move your arms a little around in space, and see if they seem to want to do something." Or, following an intuition the therapist has, it might be more specific: "perhaps it would be helpful here to try pushing with your hands and arms." The idea is for the patient to start with this suggested action and then see if it is overtaken by a more spontaneous movement coming from within.

Naturally any time the prospect of a larger movement makes a patient overly nervous, some smaller version, or even a minimal version, can be found. Affect microexpression techniques (c.f. chapter 8), in other words, frequently can play an important role in work with regressive states.

Attention to rhythm.

Crucial during such explorations are the therapist's timing and rhythm. In a sense, he now faces two seemingly contradictory demands. When aiding the patient to search out these alternative motor impulses the therapist must proceed without impatience. He must not push, but must feel out the tempo of the process itself, a tempo which at times can be very slow. Everything about the therapist's timing should here reflect a trust that somewhere within the patient the missing affectmotor resources are there, intact, "wanting" to find a path towards the foreground.

Yet at the same time the patient may be definitely in need of his interventions. So the therapist cannot just wait passively. Often the deeper the patient has gone into a regressive state, the more he is as if in an unaccustomed universe; he requires orientation. The therapist therefore must come in, helping; yet with a subtle, minimally directive guidance. It is as if the therapist is only reminding the patient: now check out this, now take account of that. But remind he does. All the levels of consciousness, even brief thoughts, can be brought intermittently into play in this way.

Residual vs. transformational images.

While the patient is exploring his motor impulses the therapist's experiential interventions should touch now and then upon the image level too. In fact during this quest for the motoric alternatives it is now and then images which can provide the most needed help. Anyone who works with body regressive states will discover before long that two highly different sorts of images are likely to show up.

Residual images and transformational images we might call them. Residual images, the more frequently emerging sort, are those which portray some aspect of a former negative situation. For example, the patient "sees" a pair of hateful eyes coldly staring at him. Transformational images manifest an almost opposite nature. They are like helpful guides, their function seeming to be to facilitate the inner re-organization which is taking place.

One client, for example, deep in a regressive experience in a standing position, began to have imagery about being in a benign forest. This evolved into a brief fantasy that, from within her forelegs and ankles and feet, growing and spreading roots were sinking into the forest soil beneath. The image itself prompted the two of us to give some new attention to the alignment of her ankles. Following a short amount of physical work in that area she then felt the "roots" spreading still more widely and firmly downwards.

Such images are fairly common. They will rather neatly "propose" valuable new steps the patient can then explore on the

sensation and movement levels.¹¹ The therapist can look upon them as healing allies.

Emotion about emotion.

Still to consider is another aspect, one normally present throughout the regressive experience. This is emotion. What should be undertaken with this dimension?

What must be well understood is that there are a number of different sorts of emotion which can show up. And these different types merit different responses from the therapist.

There are emotions, first of all, which are about the regressive state itself. About the sheer beginning presence of it, that is. The patient may be pleased, grateful, excited, curious -- just because something from his past is moving into focus. Or he may be apprehensive and fearful, again simply over the fact of the emerging state.

These represent a kind of meta-level of emotions. Usually nothing in particular needs to be done about them, but the therapist must well understand what they are. Otherwise some of the patient's reports about what he is feeling may appear contradictory, when in reality what is unfolding is quite in order.

¹¹Should the therapist also try in some more extensive fashion to interpret these images? I am doubtful. My first body psychotherapy teacher, Magda Proskauer (1968) always did so, along Jungian lines. My impression was that whereas sometimes these interpretations fitted well, more often they seemed forced.

It is the direct contact with the image itself, and with its bodily amplification, which at this point seems to me more important. (C.f. Berry (1982) on the potential therapeutic value of non-discursive encounters with images.)

An example. A patient phobic about anger has for a long time been struggling with this issue in therapy. Then, an unusual event, there emerges today a regressive state full of anger and pain. Yet simultaneously the patient is pleased, in fact almost overjoyed; here at last is some of that so-much-talked-about-and-so-little-felt early anger.

What could be more natural? Often right from the start the affects intrinsic to the state itself constitute one stratum of feeling. And the meta-emotions, so to speak -- the emotions about those intrinsic emotions -- constitute a separate stratum.

Emotion and movement.

The emotions intrinsic to the regressive state itself can also be further subdivided.

At least one of them will be directly connected to whatever movement impulse (or impulses) the patient chooses explicitly to explore. As a consequence, this particular emotion, *qua* affective quality, is certain to undergo gradual amplification. Say for example a patient in the regressive experience feels a yearning towards contact. Asked how in her body she experiences this, she might speak about "something wanting to happen" in and around her eyes. She explores that further; the eyes would like to soften, to melt a little, to "let something in". This of course is a form of movement impulse: the webbing of tiny muscles around the eyes will need to alter its position in order to create the desired "softening".

Moreover, if she chooses to let this take place in the

concrete -- if she choose actually to relax and alter the holding of the eye muscles rather than just think about doing so --, then the yearning she was feeling will almost certainly augment. To go with the movement will almost automatically intensify the accompanying emotion, even if only slightly so. There is no way to work with the one dimension of the affectmotor schema without working at the same time with the other. ("Eye softening" is a connective affectmotor schema.)

That is why the therapist must carefully judge how much or little to encourage the patient to shift from a perception of a movement impulse to a concrete engagement with the movement itself. The emotion is of a piece with the movement, the movement is of a piece with the emotion.

Affect microexpression techniques therefore are often highly appropriate when working with body regressive states. (These are the techniques which explore a tiny segment rather than the complete movement, i.e., the patient just makes a fist instead of hitting with his arm. C.f. chapter 8.) They allow the patient the most autonomy with respect to pacing, degree of intensification, and the like. Then if the patient at some point becomes sure that he wants to enter into the affect with more fullness of expression, this is always an option.

One patient, for example, feeling a motoric "eye softening" wish like that just described above, became extremely frightened. It immediately evoked an old family situation in which a stepfather new to the family repeatedly had threatened too much sexual closeness. The patient, who was then just entering her teenage years, had managed to prevent any incidents of explicit abuse. But one of her weapons in this silent war had become an intensified "keep away from me" hardness around her eyes. It proved

important in the therapy that we not proceed at all rapidly with any steps towards re-organizing this distortedly developed schema. The tiniest variations, using the principle of microexpression, were what worked well for her.

Depending upon the patient's wishes and signals, in other words, this unfolding of the impulse and its connected affect may be light, moderately strong, or extremely forceful. The therapist needs to be open to any of these possibilities while at the same time favoring none of them. He simply tracks the successive cycles of activation, follows where the patient wants to go, sees what affective temperature best fits the developing process, etc. Even with the same patient these choices will vary at different times.

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The presence of multiple emotions.

It will sometimes turn out that there are additional emotions intrinsic to the regressive state as well. A client engaged in an angry twisting of his head, for example, might at the same time feel an undercurrent of sadness. The dominant body response might now be the twisting; yet the sadness is there too. The therapist on his side might become aware of this either from the client's report, or from observed nonverbal signs, or from hints present in his own countertransference.

The question then becomes what to do with this parallel undercurrent. Generally speaking, attention should be given to it, however minimal. At the very least there should be a brief verbal exchange, the patient describing a little about how he experiences the feeling in his body. And occasionally a more

extensive exploration is worthwhile.

That decision rests usually upon two factors. First, how pressing and strong does the emotion seem to be, once it has been brought more into focus? Second and more important, what is the patient's inner relationship, in general, to this particular grouping of affectmotor schemas and subschemas? In our example, how does he manage, overall, with (a) affect programs of sadness and (b) sadness with respect to the particular theme-content which is now in play? (E.g., he might manage well with sadness in general, but terribly with loss brought about by separation. Or well with sadness in general, but terribly with a specific former loss -- for example a death of someone close -- which is now making itself felt.)

One surprising possibility makes this situation easier on a technical level: a client can usually shift his exploratory focus back and forth between two or more emotions. This is probably due to the overall condition of arousal in the body. So one can work with the dominant emotion; then leave it, and work with the parallel undercurrent; and then return again to the dominant emotion.

For example, our patient who had been exploring head-twisting movements might, at the suggestion of the therapist, pass over into a more conscious encounter with the undercurrent of sadness. This might last some minutes, with or without an expression of crying. Then, attempting to return to the anger, the patient's first impression might be that this latter has vanished. He feels nothing more of the anger, he reports. However, if encouraged by the therapist to scan carefully, he will in fact almost always discover lingering bodily traces of the put-aside affect (in this case the anger). And a trace is all that is

needed. Once even the tiniest immediate awareness has been contacted, there are plenty of technical avenues for further steps in the same direction.¹²

The significance of helplessness.

Something also must be said about one special area of affect: helplessness. It can have many variations, but in one or another form it is highly likely to show up at some point during work with a regressive state. Apathy, deadened resignation, passivity; paralysis, frozen terror; victim-consciousness; a sense of being prey, of being what the Germans call *ausgeliefert* (vulnerable or trapped); all these and more belong to the palette of helplessness.

To start with, such feelings ought not be jumped over without acknowledgement. Unfortunately some therapists here have a tendency to leap as fast as possible into something else, the client's helpless feelings being difficult for them to tolerate. But that is a mistake. This affect quality, when present, should be recognized and felt more distinctly; it should be lingered with. As he gradually gives it more inner room, the patient then can better discriminate its nuances. On occasion too, when the element of fear is particularly strong, the client may feel drawn towards more bodily expression of the fear. This also can be

¹²If even then he can't seem to recover any contact with the previously-felt emotion, a simple intervention is to propose that he just try to remember what it *did* feel like in his body a few minutes earlier. This will almost always bring about a renewed conscious contact with the feeling.

supported.

On the other hand, one shouldn't simply remain there. The client ought also to move beyond this felt condition of helplessness. Perhaps only the tiniest step beyond; but beyond. If possible.

I don't mean this in a rigid sense. There are exceptions. Perhaps the most important exception is a client who habitually flees from any least perception of inner helplessness.¹³ In that case a regressive confrontation with the condition of helplessness itself, and nothing more, may be appropriate. And perhaps not only for this session, but for several subsequent ones in which such experiences emerge. Because for this client it is a major step merely to accept that this layer exists in him. Eventually, however, he as well must move beyond. Once his (the client's) denial and avoidance have lessened, the therapist can help him with the work he really requires: a going through and beyond the helplessness by means of a new contact with inner resources.

This, really, for all patients, is one of the main purposes in dealing with regression. Somewhere in his past the client has learned that his response capacity is ineffectual. And it is precisely this learning which must now be unlearned: perhaps beginning right in this session. And if not today, then before long, in subsequent sessions. "Learned helplessness"¹⁴ is one of the major underlying causes of the stasis of developmentally arrested affectmotor schemas. But learned helplessness can be

¹³This experience is especially typical of some narcissistic disturbances.

¹⁴This invaluable notion, developed by Martin Seligman, draws together a substantial body of experimental research by Seligman (e.g, 1975) and a number of others.

overcome.

Positive emotions.

As a regressive state unfolds still further, later on it can happen that pleasurable-toned feelings also occur. The reasons for this need as well to be understood.

There can be several possible causes. One has been mentioned: a simple "meta-emotion", an emotion about emotion, concerning the fact itself of the regressive state. The client is pleased he has finally managed to reach this particular kernel of pain, anger, or whatever.

Or the content of the associative network -- what it is about, what it is representing -- may be a pleasurable memory, or in part pleasurable. Body regressive states seem normally to take us back to painful pieces of our history, not agreeable ones; but there are exceptions. Often when it is a positively-toned memory there originally were reasons why the client, as a child, was forced at some later point in childhood to repress and disown this earlier positive experience. One client around age six had to enter into a tight, emmeshed coalition with her mother, who had come openly to hate her husband. A price of this closeness was that she, the client, had to deny to herself that she had earlier received some important warm and nourishing contact with her father. Working in therapy with the body eventually brought her back in touch that disavowed part of her past.

But a third cause is much more frequent. We have just seen

how the therapist can aid the client to locate alternative motor impulses, more productive ones which mobilize affectmotor schemas normally lying outside his habitual repertoire. This in itself, no matter how minute the step taken, can easily bring an accompanying joyfulness in its wake.

That is a natural outcome: for the patient a quite unfamiliar horizon will have now opened up. At first he was experiencing only a seamless helplessness. But then, by exploring his bodily state in more detail, he was able to come across an alternative path. He chose to follow this direction, however briefly; he felt his body respond; he found how he could guide and modulate the newly emerging actions. This usually leaves a taste of competence in its wake. In a sector where the client felt devoid of resources he will have newly disclosed himself to himself as possessing agency.

A positively-toned response at this point is therefore more than understandable; it is a good sign, therapeutically speaking.

It should not be regarded as a flight, or avoidance, or a kind of splitting. There is even nothing wrong if the patient now feels rather as if he were two persons at once. The pain, fear, anger and the rest may still be present, and perhaps strongly. But so as well may be hints now of inner strength, or feelings of accomplishment, or a sort of illogical happiness.

Indeed these positive emotions occurring late in the work with a regressive state can at times become quite intense. Frequently enough they are subdued and fleeting. But on occasion their forcefulness or their special qualities may come as a surprise to a therapist who is not used to such work. A patient who is sensing this type of aftermath particularly vividly may use words like "freshness," "innocence", "feeling new". He acts

as if he has rediscovered some lost primordial faith.

Balint (1968) had a useful understanding of such moments. He spoke about the patient's sense of a "new beginning".¹⁵ That seems to me the most apt metaphor I have heard. Balint of course was referring to regression taking place in the transference: the client feeling, in other words, as if he had arrived at a fresh start in his relationship to the therapist, and thus symbolically in his relationship to others in general. But what sometimes happens during work with body regressive states is very similar. The sense of a fresh, benevolent "other" is usually in this case more generalized -- i.e, it is not centered upon the particular person of the therapist. The quality of the feeling is alike, however. The patient can sense that something new is opening up, or promises to, in his intersubjective field.

This feeling seems to be not only about the other or object, but also about the self itself. Probably that has to do with the undeveloped affectmotor schemas. The patient's "new beginning" experience partly is a statement of the intactness of these schemas. It is a joy in discovering that, despite everything, a yearned-for part of the personality is undestroyed; is there; is available; and can be bodily reached. Of course, in reality the particular schema or schemas may require extensive further work in the therapy. The patient may be far from the day when this schema will have truly made its contribution to his intersubjective "stage-setting." Nevertheless the feeling of a fresh beginning contains a kind of intuition of that potential change.

¹⁵I am grateful to Nikko Roth for calling my attention to this parallel.

Avoiding the idealization of positive emotions.

A source of possible misunderstanding must be mentioned; however. If a therapist should be careful not to depreciate such pleasurable emotions, he should also be careful not to idealize them. Above all he should not see them as the goal itself of work with regression. If they come, as a kind of coda, fine. If they do not, no problem. The purpose of the work with regression is increased contact with whatever lies deep within. That alone is the aim, not on-the-spot gratification.

This is an area which, doing supervision, I have seen can easily become a zone of confusion for a therapist. Ought a patient to "feel good" at the end of a session in which there was work with a regressive state? (Let alone feel joyous or wonderful or renewed.) I think decidedly this is a mistaken criterion, if as criterion it is taken.

A therapist who posits "feeling good" as the immediate indicator of whether his therapeutic direction in the hour has been correct, will at times end up chasing a will-o'-the-wisp. He runs a high danger of colluding with his patients to avoid essential pockets of frustration, unsureness, helplessness, longing, and the like. More realistic criteria for evaluating an exploration of a regressive state are as follows: (a) whether the client was successfully able to contact some represented part of the old childhood situation; and (b) whether he was next able to find his way to some step, however minimal, towards an increased competence in that context.

A patient may have fulfilled these smaller aims; and still have feelings of incompleteness, of wanting more, of a lack of

roundness, or of dissatisfaction. This is quite o.k. A therapist will do much more effective work with regressive states if he divorces his intentions from any particular affect-outcome. (Apart from monitoring his client's level of anxiety and making sure this latter doesn't mount too high.)

To summarize, therapeutic work with body regressive states often requires a number of distinct steps. The therapist must first judge if it even is appropriate that the patient enter more deeply into the state. If this judgement is affirmative, then the therapist encourages the patient to pay close attention to whatever seems to be occurring upon all five levels of consciousness. By this means more and more elements of the representative "network" are likely to appear. Eventually the meaning and the temporal reference (the "when" of what is remembered) will become more clear.

Further exploration should focus upon both the subject and the object poles of the experience -- the representations of self and other. Motor impulses too are carefully discriminated. If, as can happen, the client seems to be passing through a series of cycles of heightening and lowering of general body arousal, then the timing of these cycles should be respected.

In many body regressions a nucleus experience of "learned helplessness" can sooner or later be pinpointed. This too should be explicitly discriminated. A search for alternative, more productive motor impulses can then be undertaken. That in turn will often lead to a somewhat novel, for this patient, exploration of one or more affectmotor schemas which have remained in a condition of partially arrested development. Or, occasionally, it may be a distortedly developed schema which now is explored in

a new and unfamiliar manner. The goal here is some step, however modest, towards experiencing here and now how the schema can function otherwise. In a wider sense the goal is a progressive restoration of arrested and distorted schemas. Repeated work of this type can appreciably reshape much of a client's underlying affectmotor repertoire.

This is a style of working with regression which emphasizes graduated learning experiences rather than cathartic discharge.
Not that the emotions which emerge will necessarily be subdued ones; that can vary. But it is the usefulness of the learning step rather than the intensiveness of the emotional expression which is the guiding criterion.

There is still more to say, however. So far one issue I have not yet spoken about at all. Throughout this entire process, throughout these successive waves of exploration of regressive experience, what kinds of support should the therapist be offering? What forms are truly helpful and what forms not? This large question I will take up next.

Chapter 18

REGRESSION AND SUPPORT

More about regressive states. Now I will take up one of the knottiest problems the therapist faces. What constitutes appropriate support?

Imagine you are the therapist, working with a body psychotherapy patient. For some minutes, lying on the mattress, he has been exploring a regressive state, as described in the last chapter. He is deep in. Now, crying, he seems to enter a stratum of the purest pain, the likes of which you haven't seen yet from him. This is a sobbing from the farthest reaches of the body. You know well what it is about, some piece of his past just recently discussed. But it also is as if he could now be crying for all humanity.

So what will you do about this? He is on the bed, you are some feet away in your chair: doesn't that distance seem suddenly enormous? Emotion floods through you, let us say; your heart aches with his pain. Imagine as well your feelings say to you: go to him. Every biological parenting/nurturing urge which exists in you is pulling you forward. Your wish is to sit close,

to touch, to comfort. To let him know, physically, someone else is there.

But should you?

The vexing question of how and when to provide support can be a troublesome issue for most therapy forms. Body psychotherapy is no exception. If anything, the issue is even more complicated.

At first glance that might not be apparent. One might think, reasonably enough, like this. Body psychotherapy already has physical touch built into it, the therapist sometimes using his hands (at least with some patients, c.f. chapter 7) to free up constricted muscular tensions, etc. So why not (with those patients) extend this already established habit to supportive touching too? What could be more natural? Where is the problem?

How fine it would be if things were that easy. It took me a long time to discover just how complex this issue is. Years of doing supervision especially brought me to take its full measure. I repeatedly saw how mistaken modes of support could hinder an otherwise well managed case. Too little supportive touching, and the patient could well shut down his progress, or even leave the therapy. Too much, and the therapy (for reasons described below) was just as likely to stall. Somewhere in the middle there seemed to exist a right balance, a kind of zone of appropriateness standing between therapeutic withholding and exaggerated therapeutic rescuing. But how, with a given patient, to determine where that zone lies?

I will shortly share what conclusions I have come to. But first let us take a step to one side. How does this same issue

manifest itself in a classic psychoanalytic framework?

Precisely here, in my opinion, is one of the great strengths of psychoanalysis. A certain structuring of the interpersonal situation is crystal clear. The therapist listens and he occasionally speaks. But he doesn't touch. The rules of the setting are unambiguous.¹ The therapist knows it and the client knows it. Despite his occasional transference longings for other types of contact this is tremendous relief to the patient, I think. He feels it as a guarantee for his safety and his autonomy.

Moreover for the therapist it has another advantage: the guidelines are not fuzzy. There is no worrying, no fretting over what might be a "right" bodily distance. The frame has a cleanliness to it. The therapist can give his full attention to other matters.

This is not to say that a therapist doing classic analysis faces no dilemmas about support. On the contrary, the same issues show up, but on a verbal level. Suppose the patient

¹I do not mean to imply that all analysts everywhere are in universal agreement about the prohibition of touching. But those who once in a while do use supportive contact are a tiny minority. Little (1981) has offered the most extensive arguments for that point of view. I can't say I wholly agree, however.

I often supervise traditional psychoanalytic cases in addition to body psychotherapy cases. Far be it from me to claim have the last word on this intricate matter, but I will share an impression. It is that if the therapeutic frame being used is a classic psychoanalytic one, then the rule of physical abstinence is better followed with few or no exceptions. (For a particularly sensitive discussion of this point see Casement (1986)). If on the other hand touching is to become part of the frame, then it should be an explicit part - normalized and predictable. The patient's deeper sense that there are solid "rules of the game" is more important than touch or lack of touch, one way or the other.

There are, incidentally, a good many other ways a classically-oriented analyst can incorporate some of the best of the knowledge about the body which has been developed in body psychotherapy, without having to make drastic changes in the analytic frame.

cries. Should the therapist make an empathic comment, such as "I see this is painful for you"? In one set of circumstances that intervention might be appropriate; in another, intrusive or infantilizing. And, of course, precisely because any support offered can only be verbal, the finer nuances of what is said -- or not said -- take on a proportionately greater weight. Nevertheless the total range of responses which the therapist can and must consider is far smaller than with body psychotherapy.

So how should the body psychotherapist sort out what is appropriate for her or his setting?

The first step is to accept that some kind of guidelines are necessary. It simply isn't adequate for the therapist to take the general position that he will just "follow his intuitions" and "do what seems right in the moment". This is a sure recipe for countertransference confusions. Any therapist who works with the body must think through where he stands on this issue. He must establish a rough set of rules which make sense to him. In the middle of an emotionally intense session is exactly the wrong moment to sift through such decisions. One's adopted guidelines, whatever they are, need to be in place ahead of time.

Next let me make some observations about the conundrum of "too little" vs. "too much" support (physically speaking).

First the "too little." I am convinced there does exist a zone of error in this direction. For many patients, if touch is already being used with physical techniques, then to have some degree of occasional supportive touch as well is beneficial. In a body psychotherapy context, it helps them move along faster. This is true even though for the same patient, if he was being treated in a classic psychoanalytic framework, an offer of sup-

portive touch would be a mistake. Here is why.

A patient in classical analysis may have strong, even overwhelming emotions well up. He might well, at such a moment, wish the therapist would physically contact him in some supportive manner. He may even feel sad or annoyed that this type of support is not forthcoming. However, the existential affront, so to speak, will not cut very deep. For this patient, doing the therapy without touch having any role is one hundred percent what he is used to. It is what he has experienced consistently. The frame has this rule and always has had it.

The situation in a body psychotherapy is utterly different. Technical touch (work on the muscular system, etc.) is occasionally used; contact in this mode is built into the therapeutic frame. Consequently, *for a patient in body psychotherapy, not to be touched supportively can bring about sense of deprivation which is much stronger.*

That of course is no argument for an indiscriminating use of supportive touch. There are times to give it and times not (more about this shortly below), even though the patient may indeed feel a kind of deprivation. But it is a fundamental reality which a body psychotherapist must take into account: within this frame a holding back of supportive touch has different effects than within a classic analytic frame. Physical contact has already been established in the therapy as a medium, like talking and listening. For that reason, an unrelenting, total prohibition of supportive touch would be excessive, would be counterproductive for many patients. In some cases the probable result would be a collusion to avoid the stronger intensities of painful emotions. The therapy would be needlessly narrowed. (An exception naturally is when the therapist has chosen, with a particu-

lar patient, to use only physical techniques which employ no touch whatsoever. A perfectly possible way to proceed, as I have elsewhere discussed.)

So this is one side of the matter. Now the other side. What can constitute "too much" support?

During the years I have come to the conclusion that it is all too easy for body psychotherapists to overuse supportive touching. Some is certainly necessary, for the reasons just outlined. But supportive touching is a good thing which is often overdone. Either the patient is touched too frequently, and too automatically, as if the offering of physical support had become a kind of unthinking reflex. Or he is touched at times with too much surface-to-surface contact, the therapist bringing more of his own body into contact with the patient's body than is necessary for the therapy. (I will be very specific shortly below about what I think is appropriate contact.)

What has convinced me of this point of view is the following. Therapists who use the method proposed in this book are trained not only how to work with the body, but also how to work extensively and systematically with the patient's transference. As a result, many aspects of the patient's feelings towards and beliefs about the therapist are explored in detail -- including, especially, the more unconscious layers of those feelings and beliefs. This has lead to, among other things, a great deal of interesting data about the consequences, for different patients, of being touched.

The most important result emerging from these shared clinical observations is that patients can easily have unconscious negative transferential reactions to an excess of touching. They feel scared, or feel used, or feel infantilized, or feel

overly controlled. Of course they usually have positive transferential reactions too; their inner responses may be simply out-and-out contradictory. But, unfortunately, it is the positive feelings which (most often) are the easy ones to allow into consciousness -- and the easy ones to speak about to the therapist. Whereas many negative reactions remain unarticulated, both at the time of the touching itself, and afterwards.² Unless, of course, there exist means in the therapy for such hidden responses also to receive adequate attention.

Naturally a thorough transference investigation can help the patient understand many of these reactions. Usually he can then relate them to his childhood past, etc. But this fact does not eliminate our more important question: how can we reduce the likelihood of our provoking such reactions in the first place?

How can we determine a form of supportive touching which (1) helps the patient where he really needs help but (2) carries minimal potential overtones of intrusiveness, seduction, infantilization, etc?

The best solution I have found is as follows. I will not try to review all the situations which in a training context would be considered, but will summarize several general principles.

First, concerning where and how to touch. I advocate a touch that utilizes very little surface-to-surface contact. Typically either I rest one of my hands, in a comforting manner, on the patient's shoulder, back, neck, or head. Or I take one of

²Stewart (1992), discussing regression and the pros and cons of touching in a psychoanalytic context, has also pointed this out.

the patient's hands in my hand. It depends somewhat on the physical position in which the patient finds himself in the moment. At the most, a part of my forearm might rest in contact along with my hand. For example, the patient might be curled up on his side. Sitting close by, I might place my forearm and hand lightly along his arm or shoulder, or against the side of his torso.

To some readers that may sound like little. I assure you it is not. Physical touch is an extremely powerful intervention in psychotherapy. Small amounts go a long way. Even just to take the patient's hand into your own creates, for the patient, a radically changed experience. His sensory-motor system is activated; the contact channel has now suddenly become motor-to-motor. At the same time, by being conservative with the amount and style of touch, we run the lowest risk of placing unnecessary transference burdens upon the patient.³

A good idea as well is to first ask permission. Or at least to do so the first several times the occasion comes up. Later that becomes less necessary (and would in fact seem artificial), as a certain understanding will have been established.

³I should point out that these issues concern not only body psychotherapists. Some humanistic therapists using other methodologies (e.g., Rogersian therapy, Transactional Analysis, Gestalt therapy) believe in extensive and frequent supportive physical contact: hugs, holding the patient, etc. (Only some therapists. Other therapists in these traditions are more sparing with physical contact.)

Who is to say where the right measure lies? It is an obscure area. Perhaps worth pointing out, however, is an observation: as a general rule, therapists who habitually offer a lot of supportive contact of this type tend at the same time to engage rather little in any detailed exploration of the unconscious layers of transference. In my opinion it would be highly productive for therapists in these domains to build up a greater body of information about what effects are taking place in these hidden transference layers. (C.f. P. Hilton (1990) and Knapp (1992) for interesting comments upon this question as it pertains to Transactional Analysis.)

More important than overt permission, however, is what could be called covert permission. First, the therapist during any gesture of supportive touching should closely watch the patient's nonverbal clues. He may discover that while the patient verbally is saying "ok" his body is saying "not ok". Second, during the moment of touching and immediately afterwards, the therapist should pay special attention to whatever verbal comments the patient comes up with. These may have coded within them an indirect, unconscious commentary upon the fact of being touched - a commentary reflecting either positive or negative unconscious reactions.⁴ For example the patient might say overtly that he welcomes the therapist's touch. Then, a minute later, he might speak about an article he read that morning in the newspaper, about a river which overflowed its banks. The probable coded commentary: that in his unconscious perception the therapeutic field has just suffered a momentary erosion of its boundaries.

Then there is the question of how often to touch in a supportive mode. Obviously an exact directive is impossible. But a couple of points can be quite helpful.

First, my experience is that what is most productive in the therapy is some of the time, during deeper regressive states, to offer supportive touching; and some of the time not. For the patient explicitly at times to deal with these states with less

⁴ C.f. Langs (1977). Langs himself would of course deny that anything other than a strict psychoanalytic framework can be therapeutically effective. I obviously disagree. Nevertheless I find Lang's emphasis upon listening to indirect symbolic implications of the patient's discourse to be invaluable. To my mind Langs has taken this instrument farther than anyone else. In a certain sense body psychotherapy, because of its more open frame rules, is even more in need of such "supervision from the patient" than is psychoanalysis (c.f. chapters 20 and 23).

external support can in itself be an important learning process. It brings discoveries. It builds autonomy. Frequently the patient is surprised to ascertain he has more inner resources for dealing with such experiences than he would have thought. The "learned helplessness" I spoke about in the previous chapter turns into something other than the seamless void it initially appeared to be.

Secondly, the therapist must keep in mind this fundamental orientation: the goal of work with regressive states is exploration and investigation, and not gratification. Endless confusions can result otherwise. However, I must explain this point a little more, as it is often misunderstood. *

It does not mean that no gratifications whatsoever occur. Any therapeutic frame brings certain limited gratifications with it. These are inherent in the nature of the frame. In a classic psychoanalytic setting, for example, such gratifications include dependable time-space arrangements (the scheduling of appointments, etc.), quality listening, helpful clarification, and the like. Being the conditions of therapy, these come with the turf. They are also gratifications, pure and simple. Nevertheless the vast majority of the patient's wishes (e.g., a wish to socialize with the therapist outside the sessions) are not gratified.

The same with body psychotherapy. The only difference is that certain additional gratifications are added to the basic list of those inherent in the frame. These are, in addition to quality listening, etc., (1) verbal guidance for working with the body, (2) re-organizational (i.e., technical) touching and (3) supportive touching. These three additional items belong to the conditions of body psychotherapy; for the patient as well as the therapist they have a natural logic in that setting. Their

purpose too is to make the therapy possible in the first place.

In contrast, the vast majority of the patient's wishes are not gratified, no more than they would be in a psychoanalytic setting. Not gratified are, for example, a patient's desires for external social contact, or for sex, or to be fed like a little child, or for exchanges of presents. Not gratified, in sum, is the entire remaining spectrum of longing and wishes and demand. Desire is talked about, validated, understood. And with time, if the therapy is going well, desire comes to be lived differently by the client. But the satisfaction of desire is the client's responsibility to undertake elsewhere.

A useful distinction, I find, can clarify this matter ever further. It is between *accompaniment support* and *counterresponse support*.

Accompaniment support responds to the patient's wish that someone be there while he goes through a difficult experience. *This is not the same as the emerging motor wish in a body regression.* The emerging motor wish, for example, might be a desired biting, reaching, or pushing; it might be a motoric whatever. The accompaniment wish however is none of these. It is a longing coming from a different sector of the person: from that ego-sector which is "managing" the entire experience and wants assistance with the management. *Most supportive touching is in fact a form of accompaniment support.* It is a way of informing, of reminding the patient, in a manner which is more than words, that a second person is present, and is in tune with what he is experiencing. Of course accompaniment can often be expressed verbally only. But its nonverbal form also has a useful and logical niche in body psychotherapy.

Counterreponse support, on the other hand, is something quite different. If offered, it is a direct response -- a complement -- to the emerging motor wish itself.

The patient for example might be in touch with a regressive anger. A little further exploration might clarify that the motor wish therein has to do with boundaries. For this patient, let us say, there were problems during childhood with his caregivers concerning body boundaries. Some of his most basic differentiation affectmotor schemas had little chance to develop. The wish in the moment might therefore correspond to a desire to mobilize and bring out one such action pattern.

So the patient might next begin, motorically, to do just that. He might, for example, start experimenting with a light pushing movement with one arm and hand. But then his wish at this point might get more precise still. It might be a desire to push *and then to feel clear resistance to the pushing*. This desire might be connected to memories of how one caregiver was "just not there", couldn't be "felt," etc., with respect to his/her (i.e., the caregiver's own) boundaries.

So next, in order to explore the schema still further, the therapist might propose that he with his own hand now give a small amount of resistance to the pushing movement of the patient. If the patient is in agreement, this can be a useful technique. They might then together experiment with this movement and countermovement interplay. They might explore different speeds, different effort gradations, and the like. Here it is the complementary movement, the answering push from the therapist, which constitutes counterresponse support. The offered contact dovetails with the specific motoric impulse of the patient.

Now that is a gratification certainly. It is token; it is quasi-symbolic; but it is a satisfaction of the patient's desire to feel an opposing physical push. What then is its purpose? How does this offering of a countermovement fit the wider goals of the therapy?

Here another essential theoretical point needs to be understood. The purpose of counterresponse support is not to try to replace for the patient what he did not get in the past. Instead it is to aid him in forming an adequate image of what he did not get. More exactly, it is to aid him in forming an image on a motor level. "This is how it should have been" -- that is what must be grasped in motor, and not just verbal, comprehending. The "this is how it should have been" needs to be put into words too, that being an important part of the job. But for the patient something more is optimal. These conflicts from his preverbal past stand a better chance of being worked through when they can be grasped by him in a fuller form. An image which is sensory-motor, which is articulated in the body itself, can play a vital role.

And in two ways. First, a more adequate symbolic image of what should have been provides a better guide for mourning. It centers a mourning process, so to speak, upon a more exact target. The patient knows better what he is mourning for. This allows for a deeper working-through.

Secondly, it assists that side of the therapy which has to do with new refinements of the arrested affectmotor schemas themselves. These schemas, as has been remarked, have forceful "self-uprighting" tendencies. They seem however to require certain minimal outer conditions in order to emerge and to grow. Occasional doses of counterresponse support can be of a great

help here.

But both these purposes, it should be noted, necessitate only small amounts of actual contact. In addition, both allow the therapist to determine fairly clearly what his goals are. And clear they must be: for especially when deciding upon these forms of support the therapist must know where he is going and why he is going there. Otherwise he will become a good candidate for either countertransference grandiosity ("I can give everything") or countertransference desperation ("whatever I give, it doesn't heal the wound").

Such countertransference feelings, by the way, are once in a while inevitable. It would be too much to ask that a therapist never experience them, and that he never experience similar confusions. The reason is that these attitudes will sometimes arise as a result of a projective identification ("transmitted" or "induced" countertransference) coming from the patient. For example, in his own childhood, with one or more caregivers, the patient may have been made to feel grandiose ("I can give everything"). Or made to feel desperately burdened ("I must give the little I can, endlessly, even though it will never be enough to heal the other"). Then during the therapy these feelings can be mirrored and duplicated within the therapist. It is a common enough occurrence.⁵

It will also cause few problems, given that two factors are in place. First, that the therapist has well learned how to watch for, and inwardly how to decipher, "induced" countertrans-

⁵Naturally aspects of the therapist's own past may also be brought into play (c.f. chapter 23).

ference.⁶ And second, that he is familiar with appropriate guidelines for how and when to give support. A therapist who lacks this much-needed orientation runs a risk of confusing both the patient and himself.

There exist numerous variations of counterresponse supportive touching. We might look at a few typical examples.

"Anonymous hand" support. Sometimes during the course of a regressive state the patient's emerging wish is for what I call the "anonymous hand". It is a wish to be touched, a wish for physical contact from the other; but for contact of a quite particular form. What is desired is a steady, non-rhythmical, quieting, constant (for those few moments) touch. What is not desired is eye contact, recognition of the person of therapist, and rhythmic exchanges of any kind whatsoever.

Normally the patient is lying down when this type of body regression occurs. Almost always he wants to keep his eyes shut. Once the right counterresponse support is forthcoming he then goes into a sort of contented floating quiescence.⁷ There may or may not also be concurrent emotions which are less dreamy: anxiety, sadness, and the like. (Often these tend now fade to the background, at least for a while.)

Should the therapist decide to offer a physical

⁶See Downing, *Hidden Currents: Working with Transference and Countertransference*, forthcoming.

⁷Bollas (1987, pp. 256ff.) has a fine account of how similar states can occur with a patient lying on the psychoanalytic couch. Naturally in an analytic setting the appropriate support must be still more subtle. For example, the therapist says nothing during the silence itself. Then, once the patient does start to speak, the tone and/or content of the therapist's response conveys the meta-message that he understands that the silence was potentially productive.

countergesture to this state, what is required is simple enough. He needs merely place a palm against the patient's body, e.g., on a shoulder or arm, resting his hand sensitively. The hand stays in place and does not move.

Clients afterwards will usually report such an experience felt very "important" to them. Interestingly, they not infrequently will comment on the (for them) anonymousness of the anonymous hand itself. "I felt as if there was nothing else in the universe except myself and this hand," one patient said. Clients bodily find this exactly right.

Obviously the need here is for a pure "holding environment" (in Winnicott's (1965) sense) experience. Occasionally, uneasy at being so little acknowledged on a personal level, a therapist will make a mistake: he will criticize the patient for only relating to him as a "part-object", or some such notion. That is to miss the point entirely. What is wished for is indeed a kind of freedom from the other qua person. This is what a holding environment is all about. Connection affectmotor schemas are indeed in play, but they are ones whose aim is merger rather than focused contact. The therapist will reduce what is valuable in the experience if he insists upon recognition of his person. (One therapist I supervised demanded that the patient open his eyes and visually be aware of him. Error.)

Why, by the way, is this action of the therapist -- resting his hand on the patient's body -- a giving of counterresponse support, not accompaniment support? After all, wasn't such a resting of a hand one of the possible forms of accompaniment support just discussed above?

The reason has to do, this time, with the motor wish itself. In this example it is the contact itself with the external hand

which is directly wished for. It is the immediate complement of the motor seeking. It is what this particular type of connection affectmotor schema is trying to connect with.⁸

The therapist will find it helpful be aware of such differences in his purpose. Knowing when his intent is accompaniment support, and when counterresponse support, will allow him to fine-tune what he is doing.

"Ping-pong support". Here what is wished for is a brisk, rhythmic, mutually sustained nonverbal interaction. Body A echos body B, and body B echos body A. Responses and counterresponses, back and forth, with a high degree of mutuality -- a nonverbal "ping-pong" analogous to the many forms of rhythmic exchange sought by infants in their first life year.

Different sensory modalities can come into play. The patient's wish might be that the rhythmic interaction take place through eye contact and facial expression. Or through sounds. Or through gestures. Or even through light brisk pushes. Or he might not care about this; any sensory modality will seem to give the inner "click".

As usual the therapist has several choices. He might help the patient verbally formulate the nature of the wish, nothing more. And/or he might, as they talk back and forth, let his speaking rhythms quasi-match the patient's rhythms, providing in this manner a complement to the "ping-pong" wish. (Interestingly, at times a sensitive therapist will do that spontaneously without even realizing it. I have seen this from behind a one-way mirror.) Or he might find some way on a motor level to

⁸One could also say this is counterresponse and accompaniment support simultaneously.

supply a counterresponse. Lightly and rhythmically pressing one of his hands against the patient's, for example. Rhythmic mutual facial signals might also have a part. (Natural expression is sufficient. Anything theatrical would be counterproductive.)

Here too awareness of his intent will greatly help the therapist. His purpose is not, e.g., to model being playful, or to bring some new, lighter atmosphere into the therapy. The goal is much more precise: to allow the patient more fully to feel his way into the nuances of the emerging motor wish. Usually one to several minutes of an exchange of this sort is enough for the patient to "get" it.

Especially the therapist must take care that this short exchange have a true rhythmical mutuality. He must watch his own timing, in other words. He may find himself starting to take the interaction away from the patient; his, the therapist's, tones/pushes/facial expressions may begin to overlap and to dominate those of the patient. Or the opposite may happen: the therapist on his side may progressively fade. Either way, this should be corrected.⁹

A regressive exploration of this nature at times goes very deep. The patient may find himself getting in touch with something quite basic which was missing from the interactional "idiom" (Bollas 1987) of his earliest relationships. Sometimes a profound sadness, or an intense fury, can result.

"Boundary support". This type of support was already de-

⁹ The therapist should also be alert to the possibility that, if he finds himself either dominating or effacing himself from the interaction, he may be reproducing, through the acting out of a projective identification, some element of the patient's childhood (c.f. chapter 23).

scribed in an example above. The regressive state which it complements is one in which the patient uncovers a strong wish for sensing and forming boundaries. That is, for actively, physically, establishing a boundary with another bodily being. Some of his differentiation affectmotor schemas are "asking" for more evolution, in other words.

I gave the example -- a common one -- of the patient who wants to push with an arm and hand and who wants to feel something solid meeting him. But there are many other subtypes. A leg may want to push; even a shoulder, a hip, the jaw or the head. "Pushing" may not even be the right description of the movement; or, if it is offered, of the counterresponse. Occasionally a patient desires just to extend his arm (or extend a leg or jut his jaw, etc.) and hold it so, statically; and feel at the same time a light corresponding bodily pressure against it. This translates for him none the less as a bodily statement that "here is my boundary".

Naturally there can be times when an emerging motor wish would entail movements and countermovements which are not possible in the therapy setting. For example, the patient might want to make extremely strong pushes while at the same time having the therapist block his movement. But this action would be too forceful for the therapist to try to stop it. (One never takes a risk with these things.) In such a case it is almost always possible to determine some form of alternative movement which can be experimented with -- for example, a slow-motion extending of the arm which eases up against a slow-motion block. The movement and countermovement will then be not exactly what was wished, but they will be close enough for the patient still to capture some of the bodily insight he is looking for.

It is amazing, by the way, to see the fears which can surface during a regression having to do with body boundaries. Fears that, if I (i.e., the patient) use my body to assert a boundary the other will crush me; or will abandon me; or will slip through my barriers like a vapor, invading me; and the like. For many this is a preverbal area having extremely strong associated emotions.

"Background support". Here the patient wants distance. He wants minimal involvement. Yet he expects -- rightly -- the therapist to maintain his (the therapist's) attentiveness and interest. And he (the patient) wants to know the therapist is there.

Usually this type of regressive state unfolds in some direction of active bodily exploration. The patient wants to do something, to try out something; a movement usually. But he puts an emphasis upon doing it alone. He may openly say that, or the therapist may sense it through undertones and nonverbal cues.

What Mahler (1975) called the "practicing stage" of infancy nicely corresponds to the mood of this.¹⁰ As with other regressive states the patient has a "little child" feeling. But this time the "little child" persona wants autonomy, non-interference, non-intrusion. Yet he wants the attentive presence of the therapist too -- in the background. However it is not a "holding environment" wish, as with the "anonymous hand" type of state. There is more perceptual focusing, more activity; and much more sense too of himself and the therapist as separate entities.

¹⁰ The practicing substage, more exactly. This is the stage Mahler (1975) placed after "differentiation" and before "rapprochement", late in the first life-year (c.f. chapter 12).

All the therapist has to do here, as counterresponse support, is indeed to stay in the background and let the patient conduct his exploration or activity. That ought to be easy; and often it is. But not always. Surprisingly, a therapist who ordinarily is quite adept at holding himself back may here find himself intervening too much; or, worse, even breaking in with "helpful" suggestions and corrections.

This can be because the therapist, in his countertransference, has taken over the position of a former caregiver who in fact undermined autonomy. Or there may be a cause having to do with the nature of the regression itself: the patient's experience may evolve into a state less like what Mahler (1975) called "practicing" and more like what she called "rapproachment". In that case the patient on his side is likely to alternate between giving messages (direct or covert) that he wants assistance, and messages that he doesn't want assistance. Now he indicates that he would prefer the therapist closer, now that he would prefer him (the therapist) farther away; etc.

This will be perhaps bewildering for the therapist -- as it is for a mother who must deal with a child in the throes of the rapproachment phase. However, once the therapist consciously makes (to himself¹¹) a connection between the dynamics taking place, on the one hand, and the nature of rapproachment developmental phenomena, on the other, he will usually be able to negotiate these transactions without moving into an escalating conflict.

To summarize, the model being proposed here puts the inves-

¹¹Of course this reflection might sooner or later be shared with the client too. That is open.

tigation rather than the satisfaction of needs at the forefront of work with regression. When limited gratifications do occur it is for definite reasons. Furthermore, the mode of these token satisfactions is one having an intrinsic logic with respect to the given therapeutic frame. They do not contradict or dilute the frame.

I think it is instructive to compare this approach to regression to some of the experiments of Ferenczi (1955) and Winnicott (1958). These two men were among the most creative in the entire psychotherapy tradition. Certain similarities between them are also fascinating. Both, in a period when that was a revolutionary idea, had a feeling for early preoedipal developmental issues. Both emphasized the infant's real relationships rather than internal drive and fantasy alone. Both extended psychoanalytic work to patients whose pathology was so extreme they were considered untreatable according to the standards of the day. Finally, both were drawn, each using his distinctive style, to work with regressive states. They were really the first to try to think through a comprehensive approach to dealing with regression.

Both however here failed, in my opinion.¹² The direction was right. The experiments had intelligence and courage. But two essential elements were lacking -- and these were the same elements in both cases, despite the very different characteristics of the two men. First, in those earlier periods (the twenties for Ferenczi, the fifties for Winnicott) too little was

¹² Ferenczi's and Winnicott's efforts along these lines have of course been much criticized. But usually from the point of view that their attempts were misguided *in principle*. I am proposing a quite different critique, one closer to that eventually made by Balint (1968).

understood about the needs for rigor and consistency with respect to the therapeutic frame. This concept had not yet been adequately formulated. Second, the more thorough understanding of countertransference from which we profit so much today¹³ was not yet available. (More exactly, in Winnicott's case these new ideas, although just then emerging, were never really absorbed and developed by him.¹⁴)

As a consequence each found himself caught up in a spiral of escalating "parenting". Ferenczi, who hugged and held his clients, ended up taking some of them on his vacations. Winnicott tried holding and feeding; put up with visits to his home and endless phone calls; and found himself doing longer and longer scheduled sessions, as well as unscheduled ones too. Little wonder that both men eventually pulled back from the whole idea.¹⁵ Balint (1968), strongly influenced by both Ferenczi and Winnicott, tried in turn to develop a more moderate version of the same approach. But his ideas suffer at bottom from the same limitations.¹⁶

¹³See Downing, *Hidden Currents: Working with Transference and Countertransference*, forthcoming.

¹⁴In Winnicott's time Heimann's (1989) and Racker's (1968) seminal notions about countertransference were just appearing. But this current had curiously little effect on him. Winnicott did have valuable insights of his own, especially in his excellent "Hate in the Countertransference" (1958). Nevertheless the concepts of Heimann and Racker, which were far more radical, seem to have passed him by.

¹⁵C.f. Stanton (1991) concerning Ferenczi and Rayner (1991) concerning Winnicott. That wonderful document, Ferenczi's *Clinical Diary* (1988), records many the confusions and the labyrinthine countertransference feelings which these attempts provoked in him. I discuss Ferenczi more extensively in chapter 25.

¹⁶Balint at least refused to submit to escalating demands. His solution was to distinguish "benign" from "malignant" regression -- the latter comprising a more open-ended demand for therapeutic parenting. But his criteria for this distinc-

In contrast the approach I am suggesting here provides a quite different orientation. The therapist does not try to become the "good parent". He just does therapy. He does not take on pressure to fill up some bottomless cavern of neediness. At the same time, when working with regressive states, he will provide differentiated forms of support. However, he will only make available what the patient can truly use for a process of inner transformation. And he will do so in a manner which preserves the essential reliability of the therapeutic field.

That way the therapist knows where he stands with each step. Largely the patient does too. This manner of handling body regressive states has proved itself practical and viable -- for therapists of diverse types and personalities, and for patients belonging to the entire diagnostic spectrum.

Affects, to repeat a basic point, are ways we let the world appear to us. I have been developing the hypothesis here that groupings of affectmotor schemas shape our interpersonal field as we phenomenologically experience it. Collectively these schemas structure our self and object representations. They establish the "stage-setting" for our encounters with the other.

Work with the body can achieve a re-organizing of this intersubjective field at a very deep level. However, it is not the only means in therapy of gaining access to this field. Another major instrument for doing so is verbal exploration of the transference relationship.

tion are less than clear (c.f. Etchegoyen 1991). As are his criteria for, in the case of benign regression, what support to give and what not, as well as when to give it and when not. In general *The Basic Fault* (1968) is an outstanding book for raising questions; an unsatisfactory one for its answers.

The two instruments, physical techniques and verbal transference exploration, fit together extremely well. But obviously in this regard some basic questions must be raised. What does it mean to transpose psychoanalytic techniques into a non-psychoanalytic therapeutic modality? Which psychoanalytic approaches to transference (there exist today a number of them) best lend themselves to this? What changes in the techniques, if any, become necessary? How does transference exploration add to, and modify, the work with the body? And how does work with the body add to, and modify, transference exploration? All of these are issues which, in order to give them the attention they deserve, I take up in a separate book.¹⁷

¹⁷See Downing, *Hidden Currents: Working with Transference and Countertransference*, forthcoming.

Chapter 19

AN APPROACH TO TRANSFERENCE

There is much the humanistic therapies can learn from psychoanalytic object relations theory. Here and there a beginning integration is in fact already underway. In the realm of diagnosis, for example, attempts have been made better to define borderline and narcissistic disturbances. Influential too have been object relations approaches to childhood development.¹ Mahler (Mahler et. al. 1975) and Masterson (1976) have become frequent points of reference. Even more widely cited is Kohut (1971, 1977), whose "psychology of the self", though it lies outside object relations theory strictly speaking, is a kind of neighbor. These various borrowings have been creatively used, even if seldom subjected to any critique.

The great heritage of psychoanalysis lies elsewhere, however. The genius of its methodology is its central and persistent focus on the patient's transference. Needless to say, psychoanalysis is a big umbrella. Crowded beneath are highly divergent

¹For example the excellent books of Steve Johnson (1985), (1987, (1991). C.f. also Lewis (1976) and Rosenberg (1985).

trends. For that reason one cannot speak of "a" psychoanalytic approach to transference. Differences can be found even within the confines of a single school. Yet there remains a common denominator: whatever the means, transference is brought to stage center and kept there.

This is hardly the case, for a number of reasons, with the humanistic therapies at present. Here one finds less interest in general in transference. There is less concrete work with it, and little theoretical discussion of its implications. Exceptions exist, but they are rather few.²

To state the situation more exactly, let me sketch three possible attitudes a therapist might take towards transference.

(1) *The "watch for trouble" position.* Here the therapist basically goes about her/his work using other tools. Transference is not made an explicit theme unless it appears to have become a source of difficulty. Should something in the patient and therapist interaction threaten disruption, then this is addressed. As long as the therapy is moving along nicely transference is left to one side.

(2) *The "periodic check-in" position.* From time to time the therapist inquires about the patient's current feelings towards both the therapy and herself/himself. She/he presents this occasional question independently of whether the therapy is running smoothly or not. In addition, once the therapy has progressed beyond a certain point, the therapist might ask about feelings so far seldom mentioned. A patient who has spoken only of positive feelings might be encouraged to give a voice to her

²Of particular interest are Aalberse (1991), Berliner (1986), Clarkson (1992), Hilton (1980), Johnson (1985), Juston (1990), Keleman (1986), Kirsch (1986), Moiso (1992), Moser (1989), and Muller (1984).

negative feelings too, or vice versa.

(3) *The "systematic exploration" position.* The therapist actively undertakes an investigation of transference from early on. He does so whether or not the case is proceeding smoothly, whether or not the therapeutic alliance seems weak or strong, etc. More importantly, he relies little upon direct questions about conscious transference feelings (i.e., he depends little upon what I have elsewhere called experiential interventions). Questions about feelings may at times also be posed. But his principal instrument is rather (a) a frequent pointing out of subtleties of behavior and communication, together with (b) some tentative hypotheses about their possible transference meanings. The patient is then encouraged to explore, broaden, modify, etc. such hypotheses.

That kind of exchange happens often, in all stages of the therapy, with all patients. The here-and-now transference relation is not the only theme of the therapy; it shares the stage. But from beginning to end it remains a major theme.

Many therapists coming from one or another of the humanistic psychology methodologies tend, I find, to operate from some version of positions (1) or (2), an exception being sometimes made for an unusually difficult patient.³ The approach I wish strongly to advocate is position (3). My experience is that when position (3) is regularly exercised along with parallel work with the body, the resulting therapeutic mode acquires considerable versatility.

³To take one typical example, even in the excellent discussion of transference (here in the context of gestalt therapy) undertaken by Juston (1990) it is largely what I have called positions (1) and (2) which are advanced. This by Juston himself and by the dozen or so colleagues whom he quotes and cites.

What does position (3) look like in practice? There are many alternatives.

The approach to transference which I prefer has evolved gradually over a number of years. Probably worth mentioning is that a sizeable part of my professional activity consists of doing supervision. This includes, in roughly equal proportions, supervision of therapists doing one or another type of body psychotherapy, and supervision of therapists doing more traditional kinds of therapy (i.e., no work with the body). Many of them are therapists working with the more severe forms of pathology, and often in institutional settings.

This has meant my being asked for concrete help with a large range of difficulties, confusions, and impasses in which transference and countertransference problems stand in the foreground. I have been confronted therefore with the need to articulate an approach to transference having several general properties. First, it must be one which can be used with all types of patient, hospitalized psychotic patients included. Second, it must be one which therapists coming from very diverse training backgrounds can learn and utilize. Third, it must be graspable on a practical level in a reasonably limited amount of time (e.g., months of supervision rather than years of psychoanalytic training). Fourth, it must be effective as well for therapists who work with the body.

This does not imply, I should add, that a therapist who works with the body faces exactly the same transference issues as a therapist who does not. On the contrary, a point I will stress in what follows is that the introduction of physical techniques inevitably changes the transference in certain important respects. However, a common basic approach is perfectly possible.

The question then becomes what modifications are necessary if work with the body is in fact made a part of the therapeutic frame.

In this and several subsequent chapters I will give an overall account of such a basic approach. It is one which draws heavily upon contemporary object relations theory, as represented by, e.g., Kernberg (1975, 1976 1980, 1984), Searles (1965, 1979), Boyer (1983), McDougall (1980, 1985, 1989), Hedges (1983, 1992) and Bollas (1987, 1989). Kernberg's work especially has been of importance to me.

I will first describe how this approach functions independently of whether or not physical techniques play a role in the therapy. After that, I will go into the modifications necessary once work with the body is added to the picture.

A fundamental assumption underlying all psychoanalytically-oriented work with transference is that therapy from the start brings about a situation in many ways unique. Its intimacy -- its asymmetry, between one who unfolds himself and one who merely assists -- its paradoxical mix of rigid rules and open-to-anything communicative content -- there is nothing else quite like it. This has many consequences, including consequences with respect to transference. The patient quickly develops multiple attitudes towards the therapist, attitudes whose nature is largely unconscious. These manifest themselves as a tangle of overlapping and often contradictory motivations -- specific wishes, fears, fantasies, etc.

In turn these contradictory motivations leave their mark on the patient surface behavior. This is so for every patient and at every point of the therapy. The units of behavior which are

affected may be large or minute, gross or subtle -- anything from angry acting out to an overlong pause in an associational flow. The condensed, combined, pervasive effects of these underlying transference currents express themselves in dozens of forms.

The aims of transference exploration are first, to find words for some of these motivations. The patient must render them more conscious, in the senses both of being more articulated and more felt.

A second aim is to give maximum room for the transference itself to undergo evolution. It has the potential to broaden and develop, but that process will take place fully only if different threads of the transference can be made conscious. (What is of course important about this later widening is that many new themes will emerge in the therapy which might have otherwise remained unexpressed.)

Thirdly, the patient needs -- when the time is appropriate -- to link these transference motivations to other spheres, e.g. his/her childhood past, his/her outside relationships, etc. Of particular importance here naturally is the connection to the past. One after another old "object relations units" (chapter 8) are identified as contributing to transference attitudes. These "units" include, once the therapy has progressed far enough to find and clarify them, a certain number of quite primitive self-and-object patterns, i.e. ones derived from an early preverbal stratum of the patient's past.

On a technical level this progressive exploration is carried out by rather precise forms of intervention. The most frequent

instrument is a particular type of what I call a *connective intervention*.⁴

In its most ample version such an intervention might include (a) a *description* of a segment of transference behavior, (b) a *tentative connective hypothesis* about the patient's underlying motivations, and (c) a brief invitation to reflect upon this on the spot. For example,

David, since you came in you have been sitting without saying a word for fifteen minutes now. That happens often at the beginning of our sessions. I have the fantasy that perhaps part of you wants to have some help from me but another part feels a need to protect yourself. What do you think about this?

A client receiving such an intervention may or may not respond. If he responds he may or may not agree. If he agrees he may or may not take the ball and run with it a little himself. Nevertheless there is a high probability that this intervention will stimulate an internal process of reflection. Eventually -- whether minutes later or weeks later -- the patient is going to talk about these defensive tendencies, and at length, with genuine self-examination.

Each such intervention helps prepare for that moment. On the one hand, they provide him with some useful starting language (even if later he may come to change all of it.) On the other, they offer a form of support. Their subtext is that the more

⁴As will be evident below, a connective intervention is also a form of interpretation. But for didactic purposes the name 'connective' has proved more helpful, as the concept of interpretation has today become so extensively wide.

hidden puzzles of his motivation (a) are in principle capable of being verbalized and (b) can be safely and openly examined together with the therapist.

Note incidentally the "perhaps" in the example above ("I have the fantasy that perhaps..."). Far from being just a filler word, it stands for a whole interventional philosophy. It is a marker of tentativeness. It implies that the therapist could well be wrong, and that she or he knows this, and that the very project of trying to wrap words around the mysteries of motivation demands cautiousness.

Some such marker of course need not appear in every transference intervention. But they deserve inclusion often: a "perhaps", a "maybe", a "I wonder whether," a "could it be possible that," etc. It is only a slight exaggeration to say the world of psychoanalysis can be divided into perhaps interveners and this-is-the-way-it-is interveners.⁵ Having supervised a lot of both polarities my sympathies lie very much with the perhaps mode. It is a communicative gesture of a different shading: less authoritarian, less infantilizing.⁶ It more pointedly creates an implicit linguistic space in which the patient is a collaborator rather than the passive recipient of a "fact".⁷ Above all it

⁵For an example of the point of view opposite to the one I am presenting here see Levy (1984).

⁶C.f. Hedges (1992, pp. 188-9) for a fine similar discussion. And also Etchegoyen (1989) on avoiding the "oracular form."

⁷C.f. Thomas Ogden's excellent comments on the conditions of "analytic space", the interpersonal field in which meanings can be freely developed and played with. Ogden shows several ways the therapist from his side can contribute to a "collapse" of the analytic space, thereby narrowing or even stalemating the therapy (Ogden 1986). An interpretative style which can too easily take on an infantilizing edge should be

avoids the preposterous implication that offering these hypotheses we know with certainty they are true.⁸

I will later take up the problem of how to generate transference hypotheses which have a reasonable probability of being on target. That question raises issues about data and confirmation. But, separate from these technical factors, there is the matter of the therapist's underlying point of view. How does he or she conceive of, how does he/she engage himself/herself in the therapeutic field?

Doing therapy, it is less than easy to maintain an awareness of how much in fact we don't know. Especially of how much we don't know about the inner workings of the patient and her or his transference. A dozen shadowy countertransference currents work against such an attitude -- unconscious competitiveness with the patient, wishes exaggeratedly to control her or him, therapeutic grandiosity, etc. At the same time this is an area where every therapist has the possibility of personal growth. Hence an added advantage of the markers of tentativeness, the "maybe", the "could it be that." Helpful for the patient, they are probably of even more value for the therapist. They build into his own discourse syntactical reminders which are of continual use.

added to this list.

⁸Interestingly, the puns, wisecracks and koan-like gestures adopted by Lacan (1977) serve a similar purpose. They help guard the analytic space from a collapse into a deadened exchange, e.g. about "facts". In that respect they are somewhat akin to the "perhaps" polarity outlined above: they embody the beginnings of an interpretative message which, only half-articulated, the client must effectively take over and complete.

A potential problem however is that they can rather easily become a vehicle for over-aggressive countertransference acting-out. Such at least has been my impression from supervising Lacanian therapists (only some of whom incidentally intervene in this style).

Note too, in the example above, the "part of you...another part of you..." formulation ("...perhaps part of you wants to have some help for me but another part feels a need to protect yourself"). The idea there is to help the patient see that, at least some of the time, it is not just unconscious motivation but unconscious motivations -- in the plural -- which are likely at play. To aid her to grasp, in other words, that she has conflicting and competing impulses in her. This is a basic notion. It has many ramifications. It is especially important if the patient at the start is not, as is said, "psychologically minded".

Not every transference intervention needs to address conflicts in that manner. But a frequent use of this structure, particularly early in the therapy, can be extremely helpful. Of course the actual words "part...part..." are unnecessary. Other ways can and should be found to phrase the essential notion. For example, "perhaps you have feelings of X but also have feelings of Y." (Indeed the therapist in fact ought in general to vary the language of her transference interventions as much as possible.)

Note as well that in this particular example one of the two "parts" was suggested to be an area of positive motivation, positive in the sense of contributing to the therapeutic process -- "perhaps part of you wants to get some help from me...."

This too, a careful focusing on the threads, however slender, of positive intent, need be done only occasionally. But it should not be ignored. It is a helpful interventional direction, even with -- or rather especially with -- the most obstructionist or hard to reach patients.

It is effective for two reasons. First, in helping the

patient more fully honor his/her positive motivations. Unconsciously these will always be present. But some patients are only poorly in contact with them. Others are in contact but avoid, for various reasons, any verbal acknowledgement of them to the therapist. Second, in helping mitigate what otherwise might be perceived by the patient as a critical attack. If, consistently, hypotheses are only offered concerning the negative side of his motivation, then the patient may misconstrue the therapist's purpose. He may feel he is being criticized and punished rather than invited to explore himself. (A fantasy especially likely for a patient who himself is critical and punishing.) Connective hypotheses which occasionally refer to positive motivation can reduce this problem.

Like many therapists using psychoanalytic techniques I also advocate working "from surface to depth".⁹ In this respect note the deliberate vagueness of the example above: "perhaps...another part of you feels a need to protect yourself." Protect why? Protect from what? All that is left unsaid -- for now. One reason is not unduly to alarm the patient. A second is to make room for what the patient herself first can do with an intentionally diffuse hypothesis. Will she begin spontaneously

⁹A principle accepted widely but not universally. An famous exception is the Kleinian school. "Deep" transference interpretations are often made right from the start. The effect, it is thought (e.g., Segal 1967), will be to "reassure" the client (he will see that deep content can safely be addressed, etc.)

Perhaps. But I have seen what I felt were some very real problems with this interpretative style. The most serious was a lack of adequate confirmation of transference interpretations. Although this is a difficulty permeating much psychoanalytic work, it is accentuated when "deep" interpretations are not based upon a longer gathering of evidence in the therapy. I have great respect for many of Klein's insights, but there can be other alternatives for how to apply them.

to fill in details? Generally speaking it is always more productive for the patient rather than the therapist to articulate the unsaid.

Frequently however the therapist must supply more help. The patient for example may well accept that yes, in the global area of protecting himself, something indeed must be going on. But he may be consciously unable (and unconsciously unwilling) to penetrate the shadows any farther. So the therapist may find it appropriate at some later point (anywhere from minutes later to months later, depending upon an estimate of the patient's readiness) to offer something more.

He or she will then make a transference intervention which enlarges upon his/her original hypothesis. For example, with client "David" there may have already taken place some fruitful exchanges concerning his need for silent withdrawal. He has agreed that, globally speaking, wishes to protect and wishes to keep a defensive distance are at play. Little that is more specific has been put into words, however. And the same behavior has continued. (Which is typical. Many patterns of transference behavior shift only gradually and slowly.¹⁰) So now we are in a session a month later. The therapist might remark,

Here we seem to be again in one of these long beginning silences. I wonder if maybe one reason you feel a need for distance is because of a fear that if we were to become closer something destructive in you might de-

¹⁰A phenomenon for which in a sense we can be grateful. A gradual rather than an overnight disappearance of transference behaviors allows more investigation of their meaning. From the point of view of systematic transference exploration this is just as important as their elimination.

stroy me. And then you would lose the chance to get any help from me. What do you think about this?"

(Obviously, bringing out an intervention of this nature, the therapist must have some good reasons why he or she thinks it is on the mark. That is a separate problem I will take up shortly.)

Months later the therapist might well be working the same motivation

vein more deeply. The silences for some time now have disappeared. Recently however they have made an unexpected reappearance.

Therapist: Today and last time too you seem to have gone back to not saying anything for a long time at the beginning of the session.

Patient: It's true. I don't know why. It's just where I am. (Remains silent ten minutes more.)

Therapist: I'm asking myself why you might be feeling a need once again to keep a more protective distance. And I'm remembering the dream you spoke about last time, where you saw those frightening giant mouths trying to eat each other. I'm thinking too about some of the fantasies which have come up recently when you've been working with the body. Could it be that on some level you are becoming afraid that more closeness between us might mean we could both turn into something like giant destructive mouths, both trying to attack each other and both trying desperately to keep from being annihilated? Does that sound possible? What do you think?

In other words here is a transference hypothesis which seeks to verbalize a more primitive level still. Needless to say, a hypothesis of that type should be presented (independently of the question of the evidence for it) only to a patient who is already used to looking at himself or herself on this level. (That of course will be more probable if for some time now he or she has already been working with the body.¹¹)

This said, I must also voice some reservations about the "surface to depth" axiom. There is much to recommend it. It is a good road map. But there are also times to put it to one side. Because a key assumption which stands behind the "surface to depth" strategy turns out to be less than universally true.

The problem is not just, as has been remarked, that on occasion there are no clear criteria what really is surface and what is depth (Boyer 1983, Giovacchini 1969, Kernberg et. al. 1989). It is rather that a sizeable minority of patients prove to be comfortable from the outset with deeper (or at least moderately deeper) transference interventions. They will even respond better to these. A more surface intervention floats right by them; too bland, too obvious.

One only finds out by experimentation. Think of "surface to depth" as like a ladder we can climb downwards, as if into a well. The therapist must be ready to experiment with a move to the middle of the ladder, or even lower, when she senses little response (beyond simple assent) to her surface interventions. Of course that may prove a mistake; the lack of reaction may reflect hidden anxiety, rather than a need to operate at a lower rung. But in this case the patient will give easily readable negative

¹¹I expand this point in chapter 22.

signals in response to the lower rung probes.

To make the matter even more complicated, the same client is perfectly liable to be ready to work lower on the ladder in one area -- but only right from the top in another. In the general area of fears about his own aggressiveness, for example, he may react best to interventions of considerable depth. But there may also be ample evidence that he is troubled by, say, fears that the therapist might manipulate and use him; or fears that, should he successfully grow in therapy, the therapist might turn destructively envious (these are just two among many possibilities). Nevertheless with these two ladders he may be patently unwilling to go down a single rung. The therapist would then in these areas have to remain, for at least some time to come, right at the surface.

A more accurate image would be to think not of one ladder but of a number of them, each corresponding to a particular cluster of fears and wishes. How the patient reacts working along one ladder may be unpredictably different from how she will react working along others. The therapist must put aside his preconceptions. Remaining flexible, he must probe and experiment. The patient will give plenty of feedback, explicit and implicit, concerning which ladders are immediately available for exploration, and which must wait.

Confirmation (or disconfirmation) of the connective hypotheses embedded in transference interventions often requires time. Yet it should not be neglected -- an "oversight" which I'm afraid dilutes the work of too many therapists using psychoanalytic techniques.

A piece of confirmation -- a small piece unfortunately --

can be represented by the patient's simple assent. He may comment, verbally or nonverbally, that the proposed connective hypothesis makes some sense to him. This agreement may be anything from a vague "that's possible" to a firm "yes that seems exactly right." Such remarks offer only a minimal verification, however, since unconsciously the patient may be oriented more towards pleasing the therapist than a true confrontation with the recesses of his inner life. Especially early in the therapy.

A better confirmation is that the intervention seems to bring forth helpful new material from the patient. A door swings open, something comes alive, she is on to now this insight and now another one. That is a sign the intervention has reached her more deeply.

The firmest confirmations only come later, however.

One form is that repeated work going down the same "ladder" continues over time to stimulate fresh insights. The patient sees farther into the transference relationship itself; she finds new and more subtle connections with her childhood past; she comes up with better perceptions of the parallels with outside relationships; and the like.

Another type of confirmation, of equal or even more value, has to do with the "kinograms" and other material emerging when the patient works with his body. I will postpone discussing this mode of confirmation, which obviously is particular to body psychotherapy, until a little later (chapter 22).

Chapter 20

TRANSFERENCE: DEEPENING THE EXPLORATION

Some more basic elements of transference exploration.

Object relations therapists tend to place great stress, and I think rightly, on the defense of *splitting*. This is a manoeuvre much used by borderline, psychotic, and narcissistic clients. To confront it is one of the keys to treatment. Incidentally, it shows up with less disturbed patients as well, if not so pervasively. The universality of this defense is sometimes underemphasized in the literature.

Specifically what are "split" are (1) images and/or behavior of the self, and (2) images of the other, the "object" (i.e., in the case of transference, the therapist).

In one and the same session, for example, the patient for a while may act grandiose. He preens, he feels superior, others should admire him, what luck for this therapist he is there to brighten up a humdrum workday. Ten minutes later he becomes as if another person: full of doubts, repelled by himself, certain

the therapist must be bored and disgusted. Each time he is in position A, the superior stance, he sees and feels only that. Each time he drops into position B, the abject stance, the same; he has as if forgotten his life-world of position A.

Notice there are two aspects to this phenomenon. *First*, both positions are strong distortions. *Second*, little continuity exists in the passage between them. These two factors together constitute the essence of splitting. I of course have taken a dramatic example. Many versions of defensive splitting of the self are more subtle.

Splitting of the other, the object, is similar. The therapist today is seen as omniscient, saintly, someone in whose hands you could place your life. Tomorrow, suddenly nothing could be more obvious than that he is an uncaring manipulator; one should trust him with nothing. So we have distorted images again here, on the one hand; and, on the other, again minimal continuity. This too is an example more flagrant than usual (though one taken from an actual case). I use it to illustrate.

In my experience as a supervisor no other defense leaves therapists feeling quite as helpless. Especially when one or both "positions" embodies a highly devaluing image of the therapist.¹ But the other side of the coin is that systematic transference exploration of this defense can be highly productive.

An appropriate "surface" intervention could go something like this.

You say not only that you find me cold but

¹ More exactly it is the splitting in tandem with induced countertransference (i.e., projective identification) which usually is responsible for the more extreme forms of therapist discomfort. The therapist is being pressured to experience a certain affect state. This I discuss in a later chapter.

also that you think all I want is to get money from you. Yet just last session you were saying you thought you were receiving a lot of sympathy and understanding from me, and that I was the only person in your life right now you really could talk to. It looks as if you have two completely different pictures of me and as if it is hard somehow for you to get them together. What are your thoughts about this?

Notice that this intervention at bottom just describes the behavior. No speculations have been made about the underlying purpose of the splitting.

Frequently that is the best way to tackle this defense in the beginning. Some time can be required for the patient simply to grasp the reality that she does in fact carry around two or more highly contradictory images of the therapist -- not to mention two or more contradictory images of herself. Interventions with more "depth" can come later.

Kernberg (1976, 1984) especially has advocated a strong focus upon splitting defenses. In fact he proposes such confrontations about splitting as more or less the central investigative procedure during the earlier phases of the therapy (with more difficult patients, that is).² He also has a neat theoretical explanation for so proceeding: repeated confrontation over splitting, he proposes, will help the patient move from perceiving the

²Of course Kernberg includes other elements in his approach too, e.g. confrontations about self-destructive behavior, limit-setting, etc. I am confining myself here just to the handling of transference.

therapist as a series of "part-objects"³ to perceiving the therapist as a "whole object".⁴ Then, once he can emotionally relate to the therapist more as a whole object, an entire new set of transference paradigms (including oedipal ones) can move in. And these in turn can be identified and explored.

I have some partial disagreements with this last point, despite its appealing theoretical consistency. I will go into that in the next chapter. But I think Kernberg is absolutely correct to place so strong an emphasis upon splitting, and upon the need early in the therapy persistently to explore it. There are a good many patients walking into therapists' offices with whom one will not make much headway otherwise.

Second-level reactions to transference interventions are worth exploring in their own right. The idea is that the patient responds really in two ways at once. These should be distinguished. In part he reacts to the content of the transference intervention. He may think about this, amplify it, reject it, etc. In part he reacts as well to the action itself in which the therapist is engaged: the speaking, the offering, the proposing, the pointing out, etc., of the therapist. This second component he might experience, for example, as a gift. Or an intrusion. Or a kind of magic omnipotence. Or a jockeying for control. Or primitive food. Or an attempt to belittle him. There are many

³I.e., distorted, highly limited views of the therapist. Ones in which he essentially is being used to prop up a repetitive pattern of feelings and perceptions on the part of the patient. Kleinian concepts such as the "good breast" and the "bad breast" lie behind the terminology of 'part objects'.

⁴I.e., the therapist is now perceived more realistically, and with a more differentiated acceptance of his separate subjectivity.

possibilities.

These second-level reactions also can be explored. And from time to time they should be. Technically there are two ways to go about this.

One is straightforward. The therapist just poses a question. For example, "How is it for you that I am asking these things?" "When I say these kinds of things to you, how, inside, do you receive what I am saying?" It is worth the trouble, especially early in the therapy, periodically to put explicit questions of that nature. This is a point which also has been stressed by Kernberg.

There is a second way as well which I will describe shortly. However, it must function in tandem with another special technique, called "listening to the indirect commentary", and the more convenient thing will be to explain both together a little later.

Inquiry into how the patient is receiving the therapist's transference interventions has a double payoff. On the one hand it gives the therapist some guidance. Is she aiming too far down the rungs of the motivational "ladders"? Not far enough down? Anything which can help measure this is useful. On the other hand it can frequently bring to light new transferential issues worth further exploration in themselves.

A lateral intervention is another good means of bringing a focus to an investigation of transference themes. It is one of the simplest types of connective transference intervention. Yet it is often quite effective.

The patient is speaking about her relation with some other

person, present or past. To make the lateral move the therapist need merely inquire in what ways her relation with himself or herself, the therapist, might be similar.

A patient for example was talking about his relationship with another male friend. He had been musing over how, despite wishes not to, he continually felt competitive with this friend. And how at the same time he kept these feelings as hidden as possible. I asked then at what times he had feelings of a similar nature towards me. This question opened up an avenue of great importance. He had indeed already had such feelings, but with a lot of anxiety about showing them openly. To talk about them in this and later sessions proved to be a turning point in the early phase of the therapy.

Usually a lateral transference intervention takes one of two forms. "How does the same thing happen between us": that is one typical structure. Or, "how *might* a similar thing happen between us": this is a form which is sometimes more appropriate. A new patient had just told me the long saga of her wanderings from one incompetent (according to her) therapist to another. In each case within the first several months she had bolted from the therapy. I asked her for her phantasies of how she and I might arrive at a similar impasse. This led to a productive discussion. We were able to look, at least a little, at her side in breaking off the former therapies, and at the scenario from her past which possibly was in play there. We were able to plan as well for what she could constructively do (i.e., talk about it in the sessions) in the event she started feeling similar impulses towards the work with myself.

Listening to the indirect commentary is a technique of a

special nature.

The principle can be simply stated. Everything the patient speaks about -- no exception -- can be listened to on two levels. The first level is its overt, obvious content. The second is a possible disguised set of references to the therapist and the therapy -- a metaphoric indirect commentary. (In order to put this principle into practice, needless to say, there are many specifics which must be learned. I will here only sketch in a general way how the technique functions.)

An example will make the idea more clear. I mentioned above that the therapist should not only offer transference interventions, she should also from time to time find out how the patient is responding to the "fact" that she is so intervening. Now, one means of going about this is to pose a direct question -- "how do you react when I say this type of thing to you," etc. But an alternative means is to listen to the indirect commentary.

Say for example I have just made a transference intervention way down at the "depth" end of the ladder with a patient who is not accustomed to that. Content with my insight I sit back and listen to what comes. The patient, visibly impressed too on a *conscious level*, agrees with my hypothesis and adds a point or two of his own. So everything appears to be fine. Only, five minutes later he is talking about a recent trip to a dentist where the bastard started drilling without having first given him enough Novocain....

The indirect commentary, coded in metaphor, expresses the patient's unconscious perceptions of the therapist and the therapy. They also may be discrepant with the patient's conscious perceptions -- which is what especially makes this unique source of information so valuable.

The obvious next question is what to do with that information. And there will be a lot of it, be assured, for the therapist who opens his/her ears on this level.

Controversy exists there. One extreme is the position of Gill (e.g., Gill and Hoffmann 1982). He proposes that the therapist intervene often, picking up each probable reference of the indirect commentary and commenting on it. The result of Gill's approach, however, to my mind is a kind of badgering of the patient. Nothing is allowed to slip through the net. Everything must be chewed over, everything examined for how it might or might not relate, metaphorically, to the therapist. This on the one hand devalues the patient's conscious discourse. And on the other it undercuts other important areas of investigation: the past, the patient's outside life, etc.⁵

I much prefer the position of Langs (1977), who is rather at the other end of the spectrum. Langs chooses to listen silently, commenting only seldom on the information metaphorically present. The therapist however tracks the indirect commentary constantly. This has two fine benefits. First, she will learn a lot about possible errors of tone, timing, closeness and distance, maintenance of the therapeutic frame, etc.⁶ These she can simply correct. Second, she will develop a more precise picture of possible transference distortions in the patient's image of herself, the therapist. That picture can later, at appropriate moments,

⁵C.f Gill's (1985) own remark: "I think that the issue of the role of the past and how one utilizes it is one of the things that I'm least clear about". Richards (1988, p. 273) in addition makes the good observation that Gill's proposed hyper-interactive style leaves little room for positive regression in the transference.

⁶For good discussions of this topic see also Casement (1985, 1986).

be utilized in generating "depth" transference interventions.

A side remark. Langs has strict ideas about what can and can not become a constituent of the therapeutic frame. Certainly he would never countenance including work with the body as part of the frame.

I disagree naturally, but the point I want to make is a slightly different one. I am convinced that if one applies Langs' criteria for listening to the indirect commentary, what one uncovers is this. The patient's need, with respect to the therapeutic frame, is for internal consistency. The rules of the game must be clear; and they must be clearly followed.⁷ That means if work with the body is to be included, then its status must be well defined from the start. Also the rituals surrounding it -- how it is introduced, how it is carried out -- must have, for the patient, predictability and reliability. I have already spoken about this (chapter 18). In a declared body psychotherapy, for example, for the therapist *under the right typical circumstances* to touch the patient is perceived by the latter as an act belonging to the rules. Whereas in a declared classical psychoanalysis the same act, unconsciously perceived as breaking the rules, might well stimulate a torrent of metaphoric protest in the indirect commentary.

If this is right, issues about what is "appropriate" in a therapy setting are often more complex than at first glance. The

⁷It is precisely this need for consistency which Langs' own supervisory analyses of case presentations demonstrates, in my opinion. Langs presents excellent evidence (specific examples of various patients "indirect commentary" on deviations from the therapeutic frame). But in my view he overstates the conclusions which he draws from that evidence. His many examples show no more than that the patient needs a consistent frame, and not that they need *only* the frame he advocates.

influence and ramifications of the particular therapeutic frame must be taken into account.

The follow-up comes after a transference intervention. It continues the process of exploration. What is an appropriate follow-up?

This is open. If the intervention has gone somewhere, i.e., if the patient has been able to do something with it, then we arrive at a crossroads. Several avenues, all good ones, stretch out in diverse directions.

Often the best follow-up is just for the therapist to keep quiet. Let the patient feel out the next step. She may opt for one of the several avenues or she may shift to a different matter entirely.

Or, once she appears to have taken the transference exploration itself as far as he is going to, the therapist might suggest a follow-up move. For example, that the patient investigate how the dynamic just articulated with respect to the therapy relationship might also be at play in some important outside relationship (e.g. in the patient's connection with her or his partner, with her/his work colleagues, etc.).

A closer look at some piece of his childhood past might now be relevant. Or the "past" of the therapy relationship itself might be briefly reviewed. Usually this involves examining similarities or differences between the here-and-now transference behavior just explored and similar incidents which have occurred at other times.

There is however another avenue, a less immediately obvious one, which at times is much to be recommended. It is to engage in a search for the specific stimulus, the trigger, which gave

rise to the transference behavior just explored.⁸

Generally speaking, some transference interventions address a behavior which is pervasive and habitual, a kind of characterological constant -- e.g., during the first three months of therapy the patient tries to prolong the hour at the close of every session. More often, however, the behavior addressed comes and goes, waxes and wanes. It shows up only at certain times and not at others. In that case an profitable question can be raised: what triggers it? More precisely, what *this time*, in its specific here-and-now appearance, has triggered it?

The client and the therapist together carry out this detective work. Perhaps the client today has been acting cold and devaluing towards the therapist. Following a transference intervention, some of the fantasies, feelings, wishes, etc, underlying this defensive distancing have now been explored. At that point an investigation of the triggering cause could well be undertaken. The patient might recall, for example, that later in the day after the previous session he telephoned the therapist. And during the call, he now remembers, he experienced the therapist as excessively brisk and curt. Afterwards he, the patient, then put his irritation and hurt to one side. These feelings unconsciously stimulated his conduct in the subsequent session, however.

A concept I have found helpful when teaching transference exploration is that of the "middle distance" -- an affective space within which the therapist can effectively operate without stimulating some form of defensive transference reaction. This is an emotional distance, not a physical one. It has nothing to

⁸This particular technique as well has been discussed more thoroughly by Kernberg than anyone else.

do with, e.g., whether the therapist's chair has been placed near or far from the patient. It is a measure rather of the degree of intimacy; more exactly, of the patient's perception (conscious and unconscious) of the degree of intimacy.⁹

Should the therapist act (in the perception of the patient) too distant, then the patient will feel (very likely unconsciously) a threat of abandonment. Should the former act (again according to patient's perception) too close or intimate, then the patient will feel a threat of invasion or engulfment. Between these two critical points lies the "middle distance". There the therapist can reliably maneuver back and forth, now coming emotionally a little closer, now edging a little away, without causing problems. But let him cross over the critical line in either direction and he will stimulate at the least an inner transference reaction; and probably, right now or a little later, some corresponding outward defensive behavior.

The key factor the therapist must keep in mind is this: as a rule, *the more disturbed the patient the more narrow the middle distance*. Patients who come to therapy with a greater intrinsic solidness remain comfortable with wider closeness/distance swings on the part of the therapist. Patients who are more fragile can tolerate much less. Indeed many psychotic clients, and some borderline clients close to the psychotic border, can tolerate almost no movement back and forth. In that case the therapist discovers (to her or his great bewilderment if she/he doesn't understand the psychodynamics involved) the middle distance is

⁹Naturally how the therapist physically moves around the room, if he does that, can trigger transference reactions. But what will count is what the patient perceives as the meaning of these changes, and how he emotionally registers them.

almost non-existent. It has shrunk to a space so narrow that practically any action taken will violate one of its two limit points. He coughs, he is unconsciously perceived as too distant; smiles, is perceived as threatenly intimate. A steady flux of transference reactions (however muffled and obscure their outer manifestations) are being stimulated by his tiniest gestures.

A thorough grasp of that phenomenon will allow the therapist to do a great deal of transference clarification with these difficult patients. The trick is to make good guesses about which menace has just been triggered -- the abandonment fears or the engulfment fears. And to understand that behaviors of his own which to himself appear insignificant -- now he just laughed or smiled -- may sometimes in the very different inner world of the patient take on enormous dimensions.¹⁰

The middle distance concept is of help too in dealing with more "normal" patients. Their transference behavior can be investigated along the same lines. One enters, along with the patient into a search for the triggering stimulus. Simultaneously the therapist can ask himself/herself: how have I recently violated (objectively and/or in the client's perception) the middle distance? Which line did I cross over -- too close or too far? The difference with these more "healthy neurotic" clients is simply that the middle distance itself will be of a wider

¹⁰Langs (1977, 1978, 1979) also has written much of interest on the tie between an unconscious stimulus and its subsequent transference ripples. His preference however is that the therapist limit himself to a silent, private interrogation. I think Kernberg is right that much can be gained if the patient too at times is engaged in this question.

In general I find Langs excellent on many aspects of how to listen to the discourse of the unconscious. At the same time (much like Lacan, curiously) he is overly depreciative of the patient's conscious discourse. You would think the patient's conscious speaking has no other purpose in therapy than to float the indirect metaphors of the unconscious.

nature. (Should it prove not to be, then the therapist ought seriously to re-evaluate his or her diagnosis.)

Finally, at times a valuable follow-up can be to move to experiential interventions.¹¹ Particularly interventions which experientially explore body defenses (i.e., as discussed in chapter 7). What is interesting about this in the context of transference exploration is that the patient sometimes can now perceive the interplay between, on the one side, a body holding pattern; and, on the other, her or his perceptions of and feelings towards the therapist.

Suppose, for example, the theme elucidated through previous transference interventions during the session is suspicion. Now the patient can explore what he does on a body level to maintain and support suspicion. He can also vary the body holding, e.g. he might experiment with a particular pattern of tensing his neck. He could test minute degrees of a more exaggerated tension, and/or of a reduced tension, etc., all the while noticing any accompanying shifts in his affective perceptions.¹²

A *genetic analogy* is an interesting variation of transference intervention. One hints, but only indirectly, about possible parallels with the patient's childhood past. (Hence "genetic": in the sense of implying a possible genesis or origin belonging to the patient's personal history.) Kernberg has especially developing this type into a fine art, and examples abound in his writings.

¹¹A follow-up naturally which is most easily used in a body psychotherapy context.

¹²For a good discussion of the use of experiential interventions when working with transference see Keleman (1986).

Here is one. The client, a woman who has barely begun therapy, is double-binding him. The therapist responds with a long intervention, including the following.

I added that, under these circumstances, any help from me would be like the irritated, angry reaction of a parent who would prefer not to be bothered but had no alternative but to take care of an unwanted child.¹³

This can be an extremely effective type of transference intervention. Note the two key characteristics. On the one hand the therapist indirectly invokes a parent-child theme: "like the...reaction of a parent," etc. On the other hand the therapist never says, even as a hypothesis, that this dynamic might be to some extent a replay of the patient's childhood. That is subtle. The parent-child issue is raised only through an analogy. The patient is invited to look at the here-and-now interaction from a new point of view. At the same time the intervention is a kind of stepping stone to the past. It points to the past, but without the least pressure on the patient to respond on that level too.

Some patients, responding to a genetic analogy, will in fact begin talking about some parallel aspect of their personal history. Others, obviously not yet ready in the therapy for a confrontation with personal history, will pointedly avoid opening that door. Nevertheless -- and this is one of the nice advantages of this type of intervention -- often even the patient who says nothing about her past will still make a good use of what

¹³Kernberg (1984), p. 172.

has just been said. She will think and talk about the interaction in the here-and-now from a quite different point of view: as being like parent-child exchanges, or sibling-sibling exchanges, and the like.

A rather more complicated question is when the therapist should more explicitly encourage the patient to find links between what is happening in the transference and what took place, or may have, in his childhood. This issue will be taken up in the next chapter.

In sum there exists a wide range of techniques which can amplify and supplement transference exploration. Confrontation of splitting defenses; examination of second-level reactions; lateral moves; genetic analogies; listening to the indirect commentary; follow-ups to the past, or to outside relationships, or to the "past" of the therapy itself; searching for the transference reaction stimulus; and follow-ups with experiential interventions all have their contributions to make. The result is a growing shared awareness of what is actually transpiring in the therapeutic relationship.

Chapter 21

TRANSFERENCE: THEMES AND TIMING

Several points more about working with transference. I am still with general issues about verbal transference exploration, independently of whether or not a therapist happens also to work with the body. (The chapter which follows will cover what becomes different in a therapeutic frame which includes work with the body.)

Three of the most burning questions which get brought to me in supervision are these. First, when and how should one work with negative transference? Second, what does it mean to focus upon "preoedipal" as opposed to "oedipal" transference themes, and when should one concentrate upon the one and when the other? Finally, when and how should one move from a here-and-now transference issue to its probable roots in the patient's childhood past? I will take these up in turn.

As we will see, underlying the answers to all three questions is a basic theoretical point. It is that transference is massively overdetermined. The oddities of behavior which a patient manifests, in relation to the therapist, are like the

elements of a dream. Each behavioral pattern, tiny or large, which shows up regularly in the transference, has usually not one but a whole series of unconscious motivations behind it. The unit of explicit behavior condenses numerous feelings about, attitudes towards, and images of the therapeutic relationship. Even highly contradictory attitudes and images can be simultaneously in play. Probably the most frequent clinical error made in psychotherapy is to underestimate the motivational complexity of a patient's transference.

A patient begins therapy. Committed to systematic transference exploration the therapist starts in, during the early months, with connective transference interventions. What especially should the therapist try to clarify? Which aspects of the patient's unconscious motivation should she attempt to highlight?

Over the years I have come to a firm conviction about this. Early in the therapy the most important thing to illuminate is the negative transference, in my opinion. Other dimensions -- the positive transference, the erotic transference -- may require some degree of early attention too; that varies. But the highest priority is to begin to clarify the negative transference. With all patients, in all forms of therapeutic setting.

This is because it is the negative transference, and particularly its more secret and hidden layers, which poses the greatest threat to the therapy. At worst, if left unexamined, it will cause the patient to quit the therapy -- one of those unexpected departures leaving a bewildered therapist in its wake. At best, the uninvestigated layers of the negative transference will take the edge off the therapeutic process, rendering it more superfi-

cial than would have been the case otherwise.

Historically this position about negative transference was first advanced by Groddeck (1949a, 1949b, 1977), Ferenczi (1926, 1955) and Reich (1949). Melanie Klein (1932, 1975) and Rosenfeld (1965, 1987) later adopted similar perspectives (similar in the emphasis upon negative transference, though not in the means of exploration). Kernberg (1975, 1976, 1980, 1984) is perhaps its most influential advocate today. I largely follow Kernberg's approach, both theoretically and technically, with one important point of difference to be mentioned shortly.

Kernberg generously credits Reich as a forerunner, Reich's early psychoanalytic writings having been largely devoted to the problem of negative transference.¹ Kernberg's own method clinically to explore negative transference is quite different from Reich's, however. Reich kept a sustained focus upon bodily posture and muscular organization. Minute and subtle aspects of the patient's *Haltung* (attitude, posture, "holding") were pointed out to him. Kernberg approaches negative transference more from a modified Kleinian point of view.² What is examined and interpreted are not body defenses but a series of Kleinian (i.e., Klein first defined them) psychological defenses: splitting, grandiosity, projective identification, and the like.³ Reich was

¹Kernberg frequently cites Reich on this point (e.g. 1984, p. 210.) For Reich's early psychoanalytic papers, still excellent reading today, see Reich (1949).

²Much of Klein's theory and practice -- e.g., the developmental timetable, the interpretative style -- Kernberg rejects. He retains certain aspects, however. One is Klein's general description of so-called "primitive" defenses. Another is Klein's emphasis upon early oral aggression as a primary motivational force.

³I am oversimplifying. Kernberg acknowledges body elements too, in the sense of pointing out gross discrepancies between verbal content and a bodily posture or facial expres-

also famously belligerent when confronting what he thought were manifestations of negative transference in a client's attitude. Kernberg advocates a more respectful and nuanced style of investigation.

What does this mean in practice? The necessary tools have already been described. These are the various forms of connective transference intervention which were covered in the last two chapters. It is not enough just to possess the tools, however. One needs a more general point of view about when and how to use them.

First, the therapist needs to assume the following. Every patient comes to therapy with a hope, be it large or small, that he will get the help he needs. But every patient at the same time arrives with a good many more pessimistic expectations, some of which will be fully unconscious.

Think back, if you, the reader, have already been in therapy. Can you remember what it was like to start out? Or even what it was like *just to consider the possibility* of starting out? Can you remember what it cost you to pick up the phone to make the first appointment?

Certain of the beginning fears one has as a client are reasonable enough. That the journey of therapy will be painful at times, for example. And that the therapist and the therapy method are bound to have their limitations. And that the therapist won't always be tuned into you; and won't always agree with you; and won't always give you what you want. And then the expense, and the time....

sion. Also Reich on his side moved only gradually, over a period of years, from a classical Freudian style to persistent emphasis upon body defenses.

So goes a conscious stratum of doubts, regrets, anxieties, hesitations. But there is also an unconscious stratum of more primitive, irrational fears. In parts of himself the patient worries that this impending relationship is fraught with potential dangers. He is afraid to exploit and be exploited; to seduce and be seduced; to drive insane and be driven insane; to destroy and be destroyed. To what degree these more extreme fears are present depends of course upon the client, and upon what wounded him, and how deeply, in the past. *But pockets of such anxieties exist in every client, however "normal".* This is a principle one can count upon.

That does not imply, needless to say, that an exploration of these areas of mistrust must cover a lot of ground quickly. On the contrary, I am very much for slow going here -- but steady going. Tact, caution, and a willingness to define things only gradually are invaluable allies for the therapist who wishes to work with negative transference. Yet at the same time she must not too much hold back. Interventions which touch on these pessimistic themes must be made.

Naturally one precedes strategically, starting with negative motivations which are easier for the client to speak about (e.g., a fear not fully to be understood is probably going to be easier to address than a fear to be envied and manipulated). To use a concept recently mentioned, the therapist is careful about where on a "motivational ladder" (i.e., a particular subarea of feeling and impulse) she begins with her interventions. And careful about the speed with which she subsequently moves "down" each ladder. But it is perfectly possible to be attentive to this need and still not shy away from clarifying the patient's distrust, hostility, competitiveness and the like. Far from being

damaging to the therapy, this creates a much more solid foundation.

I differ from Kernberg on one important point. I strongly believe in balancing an exploration of the negative transference with a recognition and articulation of the patient's positive commitment to the therapy. By balancing I don't mean equal time or equal amounts of words; that isn't needed. Often the attention given to the patient's positive engagement can be brief. But it should be explicit, and regular, and done such that now and then it leads to an investigation in its own right.

I already touched upon this point in the previous chapter when discussing transference interventions having a structure such as "part of you...part of you". ("Perhaps part of you wants help from me, while another part feels a need to protect yourself"). I suggested then that some of the time the therapist indicate, in his connective hypotheses, one or another threads of the (often quite hidden!) positive motivation. Of course there are plenty of other ways to talk about this dimension; that was just one example. What we are looking at now is the more general role which this direction of exploration should play.

It will pay large dividends. One benefit is that it tempers the sting of looking at doubts and mistrust. The majority of patients appreciate an early attention to negative transference. They very quickly see its value. But there are exceptions. A highly obstructionist patient, asked to look at this component of his behavior, may become only the more obstructionist if he feels the therapist is now attacking and criticizing him. When his positive engagement is also validated, however, this greatly heightens the chances of his accepting some tactful confrontation

alongside.

I have had the chance to follow a good number of cases in which this principle proved its worth. Usually the therapist, in attempting to master the art of examining the negative transference, at first focused too exclusively upon negative motivations. The result was that instead of an investigative co-operation he found himself locked into a power struggle. Then, with some supervisory help, the therapist began to balance this focus on negative transference with attention to the patient's positive engagement as well. Typically the patient then shifted before very long, and started genuinely to question what is going on in him -- in both the negative and positive sectors.

Another gain is more important, however. Buried in any patient's positive motivation there is always much more than meets the eye. The underlying hopes, the wishes to receive, the arrested growth needs, the impulses to seek transformation -- these have their own complexity. Little of that is conscious to the patient. And a better understanding of this sector has its own light to shed, both upon the patient's past as well as upon the twists and turnings of the immediate transference relationship.

Moreover, on a practical level it is quite possible systematically to explore the negative transference and concurrently to investigate other dimensions. One can and should do both. Such a way to proceed I call a *wide focus approach* to transference. "Wide", in the sense that more diverse threads of motivation are given a linguistic home in the therapeutic exchange.

Let me give an example. A meek, depressed and passive client from the first session of the therapy presented an exaggerated, highly unrealistic idealization of the therapist. "This

is the safe harbor I've been looking for," "this is the first time someone has ever understood me in my core," etc.

The therapist, who in supervision was being encouraged to adopt a wide focus approach, dealt with this as follows. At times she delicately confronted the client with the hypothesis that perhaps this so uncompromisingly positive picture of the therapist was needed by her, the patient, for some defensive need. At other times the therapist suggested that perhaps she, the patient, in addition had some underlying wishes "left over" from her earlier childhood. A small child has an important need to find admirable strengths and goodnesses in a parent figure; perhaps the patient for some reason was feeling an impulse to return to that point of her early growth.

The therapist interpreted the idealization, in other words, from two different directions. One was its role as defense, protecting the patient from the threat of unconscious (and equally distorted) "bad object" images of the therapist. The other was its role as an unconscious attempt to resume early blocked growth. Logically these two unconscious purposes don't fit together. Yet as motivational forces giving rise to overdetermined behavior they are perfectly joinable.

In fact, it is as usual in transference behavior as in dreams that a single element becomes the vehicle of contradictory wishes. During the first several months of work with this client *substantial confirmation was made of both hypotheses*. And that is typical. Both types of interpretation moreover laid down some important foundations -- some preparations for later work.

(The confrontation concerning defensive needs prepared for an eventual more open emergence both of a suppressed sadistic part of the patient and of deep fears that the therapist on her side

would act out sadistically. The confrontation concerning growth needs prepared for a later emergence of a whole series of regressive wishes, many of them threatening and shameful to the patient.)

I should add that we are touching here upon some well known controversies between Kernberg and Heinz Kohut. That debate cannot be taken up in depth, interesting and important as it is. But a few comments will perhaps be helpful.

Kohut (1971, 1977) developed a form of psychoanalytic therapy which he called "the psychology of the Self".⁴ On many points, of theory and of clinical technique both, he disagreed with object relations theory. One point, for example, concerned the motivation behind much transference behavior. Often the principal factor, he postulated, is an unconscious quest to recreate the former child-parent situation, but this time in a manner such that a more positive outcome is attainable. Thus, however confused his surface behavior, the patient at bottom is seeking a continuation of early arrested growth. A second major point concerned the stance of the therapist. Kohut preferred little aggressive confrontation. Transference interpretation was to emphasize misrecognized growth needs rather than defenses. Warmth and empathy from the therapist he considered especially desirable. They would create the optimal climate for the patient to unfreeze the blocked early growth processes.

Kernberg on many occasions has strongly criticized Kohut's point of view (and has himself been much criticized in turn by

⁴Kohut adopted the name "psychology of the Self" only in his later writings.

Kohut's followers).⁵ The point on which he has most insisted (although there are others too) is that Kohut's methodology tends to leave the negative transference to one side. Since we have just seen how central the confrontation of negative transference is for Kernberg's approach, you can easily grasp the importance of the disagreement here.

So how does this controversy look from the perspective of a "wide focus" approach to transference? Let me summarize.

First, on the whole I agree with Kernberg's criticism that Kohut insufficiently addresses the negative transference.

Second, I think this matter has nothing to do with "empathy." Some followers of Kohut (e.g., Stolorow and Lachman 1980, Stolorow et. al. 1987) have criticized Kernberg for being insufficiently empathic. But these accusations and counteraccusations about empathy are a red herring. There are many modes of sensitivity and respect toward patients.⁶ The real issue is not therapeutic austerity vs. therapeutic warmth but (a) one's theory about the nature of the various motivations underlying transference, together with (b) one's decisions concerning when in the therapy to address respective subareas of motivation.⁷

Third, I do think Kohut is right about a major point: the

⁵Kernberg's criticisms are scattered throughout his writings. See especially (1975). One of the most well known critiques of Kernberg from the point of view of the psychology of the Self is Stolorow and Lachman (1980).

⁶I see even less justification for the claim (e.g. Stolorow and Lachmann 1980) that Kernberg's interpretations of negative transference in fact create negative transference. The experience of myself and my colleagues in this direction is quite the opposite. The majority of patients become less obstructionist, less acting-out, and less distant and detached through such work. One sees a slow but steady amelioration of these obstacles.

⁷C.f. Druck's (1989, p. 263) sensible comments on the Kernberg/Kohut controversy.

claim that many transference phenomena are motivated by an unconscious wish to resume an arrested current of psychological growth. Patients at moments find that transference interventions formulated along these lines speak to them very deeply. The case just described above, of the client who at the start of therapy exaggeratedly idealized the therapist, is good example.

Fourth, one can address those issues and nevertheless still work extensively with the negative transference. Nothing stands in the way of dealing with both.⁸ One comes in now from one angle, now from another, now from yet another -- a wide focus approach.⁹ I have helped a number of therapists learn to do this, and the practical results have been excellent.

What makes this so feasible is, first of all, the typical repetitiveness of most transference behaviors. They tend to occur over and over, with many small variations. One has ample opportunity to explore them from different interpretive angles.

Secondly, there is, once again, the sheer intricacy of transference behaviors. This is a point on which I continue to insist. Often they are condensations. A single behavior can draw together, as a dream draws together, the most diverse,

⁸c.f. Lichtenberg's critique of the limitations in how transference is typically viewed from the standpoint of "the psychology of the Self." Lichtenberg proposes a understanding of transference, as well as a technical approach to it, which is very close to the "wide focus" approach I am suggesting here. For Lichtenberg too the key is to take seriously the sheer complexity of the underlying unconscious motivations (Lichtenberg 1990). C.f. also Hedge's excellent *Listening Perspectives in Psychotherapy* (1983).

⁹Why is it that Kernberg intervenes so little about arrested growth needs? I have a guess about this. I suspect it is because in his approach positive regression has no major role. Instead the image of therapy conveyed by Kernberg is one in which the patient becomes, with steady and straightforward progress, increasingly adult. When he does mention regression it is usually only in the negative sense of a mobilization of primitive defenses.

heterogeneous motivational strands. The more the patient confronts this complexity of her or his desire, the better. It is one of the best routes to self-knowledge.

When should a therapist focus upon "preoedipal" as opposed to "oedipal" transference themes?

In the object relations psychoanalytic world it is sometimes suggested that the therapist avoid taking up the presence of oedipal fears and wishes during earlier periods of work with the transference (e.g., Boyer 1983, Giovacchini 1982). (This tends to be proposed especially with regard to more disturbed clients.) Instead the therapist should stay with preoedipal, pre-sexual transference issues -- e.g., fears of oral aggressiveness, envy, abandonment, and the like.

Even if overt sexual transference themes make an appearance, then, from this point of view, the therapist ought if possible to accent the preoedipal fears and impulses which may be mixed with them. For example, the patient acts hyperseductive with the therapist. The latter then should explore -- at this early point of the therapy -- the patient's need to control and dominate the affective atmosphere of the sessions.

Behind this type of recommendation stands a questionable assumption. The patient is not ready yet, it is claimed, for a confrontation with his or her oedipal history.¹⁰ He can not yet assimilate that. First he must come to terms with his "part-object" confusions, i.e., with his so highly distorted, and so

¹⁰Interestingly, Reich (1949) in his psychoanalytic writings held a similar point of view. The oedipal themes, above all others, are "depth" rather than "surface," he argued. They represent the most menacing layers of resistance, and should be confronted therefore only later in the therapy.

little differentiated, images of self and other. Only afterwards, later in the therapy, will he be able to profit from an investigation of oedipal themes per se.¹¹

I see the matter otherwise. With respect to this issue I find patients to be highly ideosyncratic. One client can accept and profit from an early focus on oedipal transference issues; another cannot. Moreover, who can and who can't seems to me totally independent of diagnostic categories.¹² For example, some patients who are extremely disturbed can nevertheless speak quite openly and authentically about oedipal issues.

Some moreover want and need to. In a case I supervised, a borderline woman patient, in therapy with a male therapist, announced in her second session that from ages thirteen to fifteen she had been sexually abused by her father. She said this greatly bothered her and that she had come to therapy in order to talk about it. In subsequent sessions however she refused to say a word more about this. Nor did she bring up any other psychologically significant themes. She spoke little, and in a irrelevant, drifting manner, mentioning only external factors in her life. She also raised questions about whether she really wanted to be in therapy or not: could she afford it, was it worth the long drive (she lived in a town two hours away), etc.

¹¹In Melanie Klein's (1975) terms, before dealing in depth with oedipal issues the client must pass from the paranoid-schizoid position (characterized by developmentally primitive defenses such as splitting) to the depressive position (characterized by the more mature defense of repression).

¹²A particularly fine discussion of the same point has been made by the Kris Study Group (Abend et. al. 1983). One could argue that what they describe as "borderline" patients are in most instances not so very disturbed. That is true, I think, but means nothing with respect to this issue. Even some psychotic patients whose therapy I have supervised responded favorably to occasional early explorations of transference oedipal themes.

The therapist chose to address the abuse issue directly in a series of gently confronting transference explorations. He attempted to articulate other possible transference fears as well. But he repeatedly raised the possibility that perhaps it might be difficult to trust the therapy situation because of what had happened with her father: perhaps she might be afraid he would sexually exploit her, etc. The patient eventually agreed with these hypotheses. She later even added that she had from the first session found the therapist attractive, and that the idea she might with time develop sexual feelings towards him was terrifying to her.

These early frank exchanges were clearly very relieving to the patient. She was subsequently able to settle down into a slow but more productive therapeutic process. My own opinion is that if the therapist had explored only preoedipal transference issues, this patient probably would never have remained in therapy.

To return again to this metaphor, I recommend testing the downwards steps of a number of different "ladders" -- each ladder representing a separate motivational subarea. Some of these ladders correspond to the different registers of aggressiveness -- envy, competitiveness, sadism, etc. Other ladders have to do with arrested developmental needs, and deep unconscious wishes to resume the blocked development. Still other ladders represent sexual and oedipal fears and desires.

Quite early in the therapy one can begin to move fluidly from ladder to ladder, helping the patient's separate out

the different motivational strands.¹³ To be more precise, the therapist should be careful not to confuse two quite separate issues. One is the problem of surface as opposed to depth: working with any individual ladder the therapist must carefully read the patient's signals about whether transference interventions should aim towards higher or lower "rungs". The other is the problem of the heterogeneity of motivations. Caution about the depth of intervention need not prevent explicit attention to a diversity of themes.

Our third question concerns how and when to shift from transference exploration into an investigation of the patient's past.

Let me begin with a problem I frequently run into when doing supervision. The therapist is in the process of learning more systematic modes of dealing with transference. As a result she is currently intervening on that level more actively than she used to before. However, a typical exchange rather too often goes something like this. (I draw upon an actual supervision example).

Therapist: ...so I wonder whether you both want me to help

¹³This approach contrasts radically with that of Masterson, for example.

In my opinion Masterson shows nicely how some borderline patients, implicitly rewarded as children for passive and self-sabotaging behavior, can repeat these patterns in the transference. From this observation he has developed a questionable methodology, however. With all borderline patients, in the early part of the therapy he confronts exclusively with regard to this issue. I could not disagree more. That is to work one motivational "ladder" and neglect the rest. In general I think it is fiction that there exist long periods of therapy when a single basic type of transference dynamic is at play. C.f. Kernberg's (1975, p. 158; 1980, p. 113f.) criticism of Masterson's approach as oversimplified.

you and at the same time are worried that if you accept my help I will try to control you.

Patient: This makes a lot of sense to me. My mother was so controlling. I hated it.

Therapist: Tell me about your mother.

For this patient, "mother's controlling" is doubtless an important piece of the past to investigate. The present session may even be a good occasion to start. But the move to the past here came too soon. It cut off anything which the client might herself have next opened up concerning the here-and-now transference relationship.. Were the therapist consistently to follow up in this manner, she would send an implicit but powerful message: "please don't talk too much about what is going on here-and-now between us. A little yes. A lot no, as that might create discomfort on my side." An invitation to a form of collusion would thus be offered.

Instead what must be learned is a willingness to linger with these transference exchanges. Even at the price, on occasion, of some passing awkwardness and confusion on both sides. The patient's childhood can also be brought into the picture whenever appropriate. But not with so hasty a jump.

On the other hand I think it is fine, and indeed helpful, to start making these connections to the past fairly early in the therapy. One need not in any way push the patient into this. Should he refuse, for example; or should he in fact have no memories; or should he insist he had exclusively good experiences in childhood; then no matter. Therapy can move along anyway. His confrontation with his history can come later. But if in fact this confrontation can begin earlier, all the better.

One excellent reason is the inevitable help this will give to the process of transference exploration itself. The more the therapist learns about the contours of the patient's past, the better will be his hypotheses about the hidden strata of here-and-now motivation. His transference interventions will improve in quality.

Another advantage is it can sometimes be a healthy shock for the patient to see how a provocative piece of behavior may represent a repetition of some trait of one of his former objects. Often this is a trait the patient himself holds to have been destructive or, at the least, disagreeable. He may thereby take a first step towards regarding his own action as ego-dystonic.¹⁴

But suppose a client obviously uses talk about her past to evade the here-and-now transference investigation. The therapist notices that whenever he, the therapist, tries to probe the here-and-now relationship, the client slips at once into some or another kind of long reminiscence about her childhood. What then?

Fortunately there is a good solution to this problem. The therapist deals with the slipping to the past, the deflecting and evading, just as he does with any other transference behavior. He politely confronts, describing what he sees the patient doing; he (the therapist) proposes connective hypotheses about what it might be in the here-and-now relationship which is difficult for the patient to look at; he invites the patient to explore this further; etc.

Sometimes a therapist worries about another issue: that the

¹⁴Kernberg (1987) takes a different position here. He argues that first the action must become ego-dystonic before the step to the past can be considered. I find that in practice the reverse sequence often works quite well.

client, speaking about his childhood early in the therapy, may do so with little affect. The speaking about the past remains emotionally flat. Does this imply, as some therapists conclude, that it was a mistake therefore to allow the client to discuss these things so soon?

Here we have a potentially more complicated situation. A distinction must be made.

First, for a patient to confront a sector of his past about which he is highly anxious, and about which he is unused to reflect and to speak, an initially "flat" account is sometimes quite appropriate. The pertinent question is whether or not this is new for him, even just to talk about this area of his childhood, or about this aspect of it. If in fact it is new, then the flat recounting represents no problem. The relevant affects will come later in the therapy. (Indeed if work with the body is intended as a part of the therapy, one can absolutely count upon their eventually showing up.)

Second, when instead a patient is only hashing over thoughts and memories which are already familiar, and little new is emerging out of that, then this issue in its turn can be directly addressed. The therapist helps this patient investigate why he allows himself only to confront the past in a deadened way, and in an overly familiar way. Indeed the transference dimension of adopting a deadened manner can profitably be clarified.

Another reason sometimes given for postponing such steps to the past is that many disturbed patients early in the therapy, are thought to be not yet ready to get in touch with accurate memories.¹⁵ Instead, their images of the past might well be

¹⁵Kernberg (1976, 1984) has occasionally raised this problem.

grossly distorted. Therefore better to wait.

But first of all, one must reply, that is only sometimes true. A decent percentage even of psychotic patients are able to reconstruct a reasonably realistic image of their pasts (given that they are willing to talk about it in the first place, which is quite another question). Second, concerning those who do in fact present a distorted picture (e.g., mother was a saint, father a monster), is this so serious? Where the distortions are obvious the therapist can delicately help the patient look, bit by bit, at the significance of these distortions (i.e., in this example a defensive need for good object/bad object splitting). Where they are less obvious, or where the therapist feels unsure about their reliability, she can simply wait. Nothing at all requires her to take an early position about what objectively may be true and what not.

At the same time let me say again that there is no need early in the therapy to pressure patients to make these moves to their personal history. A better message for the therapist to give is one along these lines: this aspect too can be examined when you feel ready. Even later in a therapy, when a patient repeatedly and stubbornly resists opening up an investigation of her childhood, my experience is that the problem always in part has to do with the transference relationship -- and usually, with a complex transference-countertransference impasse. Instead of engaging in a spiralling power struggle over whether or not to discuss the past, the therapist will be much better off putting his or her attention to the transference difficulty itself, and trying to clarify what is happening there. Once that knot has been unravelled, or at least partly, the patient will be more ready to face whatever it is which so frightens him in his histo-

ry.

To sum up, a valuable working hypothesis is that early in a therapy multiple strata of motivation are in play concurrently in the transference. Naturally as the therapy progresses these transference feelings, wishes, defenses, etc., will shift and evolve. But even in the earlier stages there is everything to be gained by starting to illuminate these various currents by means of transference interventions.

A "wide focus" approach allows the therapist to do justice to this underlying motivational complexity. Negative transference is explored systematically, but without precluding a validating and clarifying of positive motivations. And without precluding a recognition of arrested growth needs showing up in the transference. In addition, when the patient's behavior or associations indicate they may be in play, the therapist addresses motivations revolving around oedipal conflicts and defenses against such conflicts. She or he does not operate (including with more disturbed patients) with a fixed strategy of addressing preoedipal transference issues early in the therapy and oedipal ones only much later. In general, at all times the therapist operates with the expectation that transference behavior is likely to be highly overdetermined.

Some discussion of related aspects of the patient's personal history can also be appropriate during the early months of therapy. However, the therapist is careful that neither she nor the patient such a discourse as a means of avoiding a continuing examination of the here-and-now transference relationship.

So far I have been discussing this approach to transference only with respect to therapy in general -- i.e., independently of

whether or not work with the body might be involved. I will now turn to what is more distinctive, and what becomes different, in body psychotherapy.

Chapter 22

TRANSFERENCE AND THE BODY: WHAT IS DIFFERENT

How could you introduce a major change into the therapeutic frame and not have it affect the development of transference? And what change could be more major than adding physical work with the body?¹

In the preceding three chapters we have been looking at transference in general. A particular technical approach, based mostly on the work of Kernberg, was recommended. It is a basic way of proceeding I would advocate for any form of long-term verbal therapy.

However body psychotherapy is not psychoanalysis, and psychoanalysis is not body psychotherapy, even if it is possible at many points to draw their methodologies together. Therefore it is essential to pose the question of what is special about transference in body psychotherapy. And to examine what this implies

¹It is striking that in the existent body psychotherapy literature transference is rarely discussed. Still more surprising is that, when it is mentioned, usually nothing is said about its perhaps having some important differences from how transference typically develops in other forms of therapy.

on a technical level. Here are what I find to be the major differences.

1. *Preoedipal transference wishes are felt by the patient with more clarity.* A body psychotherapy therapeutic frame means that the patient will sense these desires in a more differentiated manner.

That is probably the largest difference between how transference evolves in body psychotherapy as opposed to other therapy forms. We have already seen how work with the body, through the emergence of motor "kinograms", brings about more contact with the preoedipal, preverbal past. This is of course a particular advantage of body psychotherapy, as has been discussed. But a related advantage as well is its consequences for working with transference.

There are of course many types of wishes towards the therapist which develop in body psychotherapy. In general the overall amount of transference longing seems not greatly different from other long-term therapy forms. Nor does the spectrum itself of these longings. There develop preoedipal transference wishes, oedipal transference wishes, post-oedipal transference wishes -- the full range. All this is much the same. But there is a noticeable difference with respect to the manner in which the preoedipal wishes emerge. Generally speaking, the patient (a) will discriminate them in a more nuanced fashion, (b) will feel freer to speak about them and (c) will describe, elaborate and investigate them more adeptly.

The value of therapeutic attention to preoedipal transference wishes has been much documented in the object relations literature (e.g., Winnicott 1965, Boyer 1983). And without doubt

one major contribution of object relations theory has been to show the sheer massiveness of preoedipal transference. However on the level of technique itself -- how to pinpoint such preoedipal elements, how to find language for them, how to persuade the patient of their importance -- there has been less development. The most creative suggestions have been in the area of the therapist's inner verbalization of her/his countertransference (e.g., Boyer 1983, Searles 1965, 1979, 1986, Ogden 1982, Bollas 1987, 1989, 1992, Hedges 1992). Now certainly that is a rich vein; but given its inherent vagueness and its limited possibilities for verification, one would like it to be backed up by something more solid.

A body psychotherapy setting thus has much to offer on this score. A number of psychoanalysts I have trained have commented upon this. Their evaluation has been that the work with body allows them to do still better what they were originally trained to do. A critical area which had always remained somewhat obscure takes on a new clarity and approachableness.

This increased ability on the patient's part to discriminate preoedipal wishes is a natural outcome of the work with the body. One does not see its effects right away of course. The phenomenon I am talking about belongs to the middle and late phases of the therapy. The patient must have already gone through some experiences of positive regression while working with the body. Thanks to those experiences he or she is now more knowing about the feel of "early" wishes on a bodily level. And he is more accustomed to translating them into images and language.

Of course the wishes that come up during the body work itself usually are not perceived as "aimed" at the therapist.

That is a distinction we must not lose sight of.² Their "object" is a kinogram-embodied remembered object from the past -- a vague sense of an outside force, an image of huge warm embracing arms, etc. The person of the therapist is mostly to one side, off-stage. Nevertheless two key skills are being developed in these moments: the sensing skill (feeling the wishes) and the elaboration skill (fitting images and language to them).

It is the build-up of these particular skills which has, for the transference, some definite consequences. During the work with the body the person of the therapist may at times become less central. But when at other times (outside the sessions, in other sessions) there arises some kind of preoedipal-toned longing towards the therapist himself, the patient will now be more open to that experience too. He has become more tolerant; he knows it is not so peculiar to harbor such feelings. He has become more tuned-in, bodily. He has become more savvy about the worthwhileness of the image-and-language translation, and about how to bring that about. Inevitably he will feel some barriers - - shame, related sadness and/or anger, and the hard knowledge (c.f. chapter 18) of the impossibility of gratification. But those barriers will exert less power over him than would have been the case otherwise.

What however about the fact that a tiny fraction of these wishes do on occasion meet with a real satisfaction? For example the patient feels a wish to be touched by the therapist. And in that session perhaps the therapist, working say a few minutes on

²One could argue that, a priori, they "must" be displaced transference wishes. I doubt it. Having seen this phenomenon countless times, and having frequently had this question in mind, I am convinced that the emerging kinograms are often independent of the person of the therapist.

muscle tension in a shoulder, does indeed touch him. Does that type of event in any way confuse or undermine the verbal transference investigation of preoedipal wishes?

Hardly at all. For the simple reason that what is desired, greatly -- I am tempted to say infinitely -- surpasses what is given. Longings emerge (sooner or later) for an entire phenomenological world of healthy parental touch, for example. The brief (and, however tuned-in, eminently "professional") touching of the therapist is from that point of view a minimal satisfaction only.

This situation is closely analogous to the good-quality listening provided in a purely verbal therapy. Of course one listens well, or tries to; that is basic to the frame. And in a limited way too this is a "gratification" for the patient. But eventually she will come in touch with her impossible longings in that dimension -- wishes to be understood to her core, wishes to be "explained" to herself from outside with perfectly accurate phrases, wishes that the timing of the other's speaking be perfectly attuned to her own rhythmic needs, etc. And these longings can then be explored with a depth a gratified wish cannot be. Minimal gratifications which are a necessary part of the therapeutic frame create few obstacles to transference exploration.

This does not mean that in body psychotherapy the therapeutic field is automatically free from confusions on this score. For example, I have occasionally seen a situation where a therapist in a body psychotherapy modality was attempting by means of the physical techniques to be an all-giving, "good" parent figure -- i.e., attempting massively to gratify the patient. In these instances there were corresponding blocks and confusion on the

level of transference exploration (including, usually, a collusion to avoid and deny the negative transference). But here the underlying causes were countertransferential ones (c.f. the discussion of countertransference "traps" in chapter 24). They were not intrinsic to the body psychotherapy frame itself.

2. In a body psychotherapy many "depth" transference interventions in the middle and the late stages of the therapy can be made more precise.

I just discussed how the patient himself at times comes better to discriminate preoedipal transference wishes. But there is a related gain for the therapist. Remember, her task, with respect to exploring the relationship, is not just to listen to what the patient has consciously, spontaneously, happened to notice. Her task is also to offer connective transference interventions -- i.e., interventions which propose a hypothesis about transference wishes of which the patient may at the moment be unaware.

That task too, insofar as it relates to preoedipal wishes and conflicts, is very much changed by the work with the body. To understand why, consider a practical difficulty.

In the three previous chapters I have spoken about working from "surface to depth" in exploring transference. I used the metaphor of a progressive movement down parallel "ladders," each ladder corresponding to a different motivational subarea. Here the therapist faces a problem, however. It is perhaps the largest difficulty belonging to any psychoanalytic or psychoanalytically-oriented approach. How is one to get down to the lower rungs? Where is the necessary information to come from? Once we leave the higher rungs, with their more obvious interpretations,

what can we use to guide us?

One does have clues. The therapist will have learned some things about the patient's childhood and family of origin. The therapist will have her on-going grasp of defenses and characterological make-up. The patient's dreams may also give indications. Perhaps too the therapist has learned how to "read" her own countertransference. These are all helpful channels, yet at bottom they are extremely limited. About the most primitive motivational layers they yield only vague hints and ambiguous suggestions.

Hence the dilemma for the therapist. Should she stay with the upper and middle rungs of the various ladders, refusing to go lower? That runs the risk of making transference exploration go stale in the middle and later parts of the therapy. Or should she, despite much uncertainty, make his transference interventions aim lower down? That runs the risk of excessive guesswork.

This situation distinctly improves in body psychotherapy because the therapist has a rich additional source of information in the body work itself. The client goes into regressive states; old conflicts come up; language is fitted to these experiences; etc. That is important in itself; but also what the therapist learns in these moments can then be used in later sessions for exploring transference. The therapist has learned with much more exactness than could otherwise be possible what the unconscious regressive landscape of the patient is like. She has seen some of the primitive affects and the primitive desires in their specifics. She has heard the words the patient himself has chosen for describing his motor representations of self and other.

"It is very hard to deal interpretively with very early transference affect," comments Valenstein (1985). Of course it is, if the language for these early affects is not already in circulation in the therapy. But it is much more feasible if, thanks to the deciphering of kinograms during regressive states, that language has in part been already discovered.

Drawing on those hard-won words and phrases the therapist can generate new transference interventions. These can be developed with a specificity and depth which earlier interventions tended to lack. At the same time these new interventions will have a higher probability of accuracy. The therapist knows they correspond to a stratum of affect and fantasy which the patient possesses inside himself or herself.³

In addition the patient on his or her side can better respond. He can do more with these offered hypotheses -- modify them, reject them, elaborate them, etc. That is because of his increased inner contact with early desires and affects, as discussed just above. The dialogue on both sides can take place with an sophistication which otherwise would be difficult to attain.

3. *The parallel roads.* Here is a curiosity peculiar to body psychotherapy. There can be plenty of times in the therapy when it feels as if not one but two transferences are going on. One is centered around the verbal work (i.e., the verbal work which

³This is not to say that accuracy is guaranteed. The therapist, making an intervention which speaks about fantasy X, might be correct that X exists in the patient but wrong that it is in play at the moment on a transference level. A quite different fantasy might be dominant at the moment. Even with the help of information from the work with the body there is still plenty of room for error and plenty of need for attention to verification.

is done separately), and one around the work with the body. They feel like two parallel roads which run at a slight distance from each other.

In reality of course there is one transference. It has simply been divided into separate currents, a different underlying "object relations unit" (or, usually, a different constellation of them) setting the tone for each.

It is a ubiquitous phenomenon. It can happen in any therapy, with any patient. It can continue for weeks or even months.

For the therapist unaccustomed to this phenomenon it can set him spinning the first few times he encounters it. Here he is working with patient Helen. For some weeks now the, so to speak, purely verbal countertransference has been thorny, confusing, charged with a murky hostility. Yet every time the two of them shift to working with the body the atmosphere suddenly lightens. A mood of relaxed, easy contactfulness sets in, as if someone had thrown open the curtains in a dark room. "At last," he (the therapist) thinks silently, becoming comfortable. But later in the session after the work with the body is over -- or right away at the beginning of the next session -- it is back to the bristling confusion. The comfortable moment might not have happened.

A second example. Here he is with patient Susanna. In this case the purely verbal work currently has a kind of glow to it. There is a closeness, a kind of excitement, a sense of synchronized team work. But whenever they move to work with the body something goes flat. An emotional distance is suddenly present, a stagnation in the connection. Then, once back to the purely verbal exchange, the relationship feels alive again.

It is more complicated, moreover, than just a question of different experiences at different moments. Often one discovers,

over time, a certain internal consistency within each "separate" transference. For a number of sessions the body-oriented transference will have its own logic, its own flow; and the speaking-oriented transference its quite other qualities. Each manifests its own internal development like a piece of music which, interrupted from time to time, is begun again at the point where it last was stopped.

At first glance one would want to call this phenomenon a kind of splitting defense. I don't think that is right, however. Trying to interpret along those lines typically only creates confusion. What I have learned is instead to accept it as a natural course of affairs. It is going to happen, and relatively frequently. And it does not present any particular obstacle or difficulty.

The therapist just needs to understand its likelihood in body psychotherapy. Different elements of the therapeutic frame seem to provide different hooks upon which transference attitudes can be conveniently hung. The therapist should simply accept this without any criticism, explicit or implicit, of the patient.

He or she should of course take careful note of the atmospheric nuances belonging to each of the "two" transferences. Also he should feel free to explore both through transference interventions. He should expect too that the object relations units dominating one transference may well show up later in the other. Not to be recommended, however, are confrontations directed towards the existence itself of the "parallel roads."

4. *The sexual echoes.* This is a transference current which occurs early in the therapy. It concerns the client's fear,

usually unconscious but sometimes conscious, that work with the body in therapy is sooner or later going to lead to sex.

A therapist practicing body psychotherapy must realize that some unique transference implications are present from the start of the therapy, even if it may be a long time before physical techniques are actually used. (I am assuming of course the patient knows at the beginning, as normally he or she would, that the therapy later will include -- or at least might possibly include -- direct body techniques.)

Even if, for example, the entire first year of the therapy is done without a single body intervention⁴, still the patient knows that the physical work is coming (or at least that in principle it is a possibility in the future). This changes his fantasies about the therapy and the therapist. "Here in this office patients like myself sometimes lie down...they breathe more deeply...they are supposed to feel their bodies more...they have emotions...a strange business...and I myself might someday be trying it...." These are reflections which add a new thread to the transference. Not that patients entering a purely verbal therapy are free of fear that professional closeness might spill over into sex. But a patient at the start of a body psychotherapy has a natural likelihood to feel this uneasiness more strongly. (That tendency will be there whatever the gender combinations, incidentally. An opposite-sex therapist will elicit heterosexual fantasies and fears, a same-sex therapist homosexual ones.)

⁴I mean, without external body techniques. Usually during the preparation period (i.e., before one works with external techniques) there will be no problem with occasional use of light internal body techniques; even with quite disturbed clients.

These anxieties -- which, to repeat, may be conscious or unconscious -- tend to reach their most acute point *just prior* and *just after* the first few sessions in which work with the body is first introduced. A situation I periodically encounter when doing supervision illustrates the importance of these concerns and doubts. A therapist thinks the therapy he or she is doing with a particular patient is going just fine -- there has been progress with symptoms, the working alliance seems good, etc. So far, however, there has been no work with the body (i.e., work with external body techniques); this has been postponed, for the usual right reasons (c.f. chapter 4). Finally both therapist and patient have decided, also on good grounds, that the time has come. The patient works for the first time with his body, it goes quite well, as he leaves he is visibly pleased. Then two days later the patient calls up and announces without explanation he is quitting the therapy.

In most of the instances where I have been asked for supervision help at such a point, the therapist and I were able to determine what had happened by reviewing details of earlier sessions. Typically we found a series of small hints and clues which the patient had been dropping for some time; mostly these were manifested in the "indirect commentary" (chapter 20). Prominent in their content was a high level of anxiety about the "sexual echoes" of the prospect of working with the body. Often this unconscious reluctance was quite at odds with the patient's conscious expressions of enthusiasm.

In a good many of these instances the therapist, following my recommendation, was able with a second phone call to get the patient to return and discuss his or her decision. The fear of sexual implications was then openly addressed. Typically that

discussion, with some accompanying investigation of related themes in the patient's childhood history, was enough to put the therapy back on track.

In my experience, however, it is usually possible to prevent this problem in the first place. My suggestions for doing so are as follows. First, during the pre-body-work period of the therapy the therapist should be especially alert to any indirect hints that the patient may have transference fears about seduction. Connective transference interventions exploring any such cues should be offered on the spot. A therapist who never works with the body perhaps can wait before addressing that transference level, but a therapist planning to bring in physical interventions does not have the same luxury.

This doesn't mean incidentally she or he must right away work in depth with the seduction fears. On the contrary, better that she or he just test the water. It will soon be evident to what extent the patient seems prepared to explore those fears -- as happens with any of the transference motivational "ladders." But the therapist does need to get a few of the right words into the air. These anxieties should receive a name; that is the minimum.

Second, I recommend that in the session where for the first time there happens work with the body the therapist say something like the following.

It is very important that today after the session, and during the next days until we meet again, you pay close attention to any new feelings which might come to you either about me or about the therapy. Sometimes

working with the body can bring up a whole set of new feelings. If you should notice anything like that going on, it is important you try to talk about it here the next time we meet.

Suppose in addition that during the earlier pre-body-work period some transference seduction fears have already been discovered and discussed. In that case it would be worthwhile now to add something like this.

For example, a couple of months ago we discussed some nervousness you were feeling then about the idea that I might try to have a sexual relationship with you, or that you might try with me and I might go along. These feelings might also come up again now that you have begun actually working with the body.

Under many other circumstances both these admonitions -- the suggestion to keep an eye out for transference feelings and the suggestion specifically to watch for anxiety about seduction -- would be inappropriate. The patient already knows that transference responses are grist for the therapy mill; perpetually to remind him or her in this way would be infantilizing. But when work with the body is first introduced it is an exceptional moment. A statement along the lines of the above examples is very much called for. Therapists who have used this with their patients have reported excellent success in dealing with subsequent transference reactions.

The "sexual echoes" fear, incidentally, is one which normal-

ly fades away once work with the body is occurring in the therapy on a regular basis. The reason for this is obvious to anyone who has been in the client position in body psychotherapy. Work with the body is erotically demystifying. It is much more unsexy than sexy. There can be moments of frisson, but for the most part the experience is one of encountering muscular tensions, altering their configuration, tracking movement impulses connected with all sorts of affects, discovering memories, etc.

Interestingly, even if it happens that sexual feelings arise while the patient is actually working with the body, those feelings are seldom experienced as directed towards the person of the therapist. Perhaps that is a kind of defense, or a reaction to countertransferential defenses, but for whatever reason this is the way it usually happens. Normally either the patient feels aroused in a global way, an unfocused body mood. Or he or she has images of a desired specific person from his/her environment. (You could argue that the latter instance is a displacement of feelings which really have to do with the therapist. But I doubt that. It doesn't check out if verbal explorations are made of this possibility, and it doesn't check out with the atmospheric feel of the situation.)

This is not to say that patients in body psychotherapy do not develop sexual longings towards their therapists. They do, consciously and/or unconsciously, and in many variations of desire. But on the whole they tend to experience these feelings or their derivatives (a) outside the sessions and (b) during periods of purely verbal exchange within the sessions. In short, erotic feelings towards the therapist, to the extent that they occur, develop in more or less the same manner as in any other long-term therapy form. The work with the body makes curiously

little difference one way or the other.

5. The shadow of existential dependency. This is another transference fear often stimulated more strongly by a body psychotherapy setting. Usually however it comes to a head somewhat later than the "sexual echoes" fear.

It is a fear about dependency, but of a very particular type. It is a worry which might be expressed so: "If I go any farther with this therapy, my insides are going to shift around and change far more than I had expected. And that means there will come a period of transition during which I may be very confused about who I really am. And I may then very well become dependent upon this therapist in a frightening new way. She/he will have to become the overseer, the manager, the director of my growth. I will be too much in the thick of it all to see where I am going." It is a fear that the therapist in a wholly unforeseen way is going to become the rock to which one clings.

It is a small-child fear. More exactly, a fear about (a) returning to a small-child arrested growth point, (b) resuming the growth, and (c) having a guardian of this growth whose shaping role corresponds to one's parents' original role. Thus at bottom it is an anxiety that one's new growth will be damaged. An anxiety that one will re-experience the hurt or the abandonment or the distorted shaping one suffered before. It is a fear and wish both, really. The wish is that the former blocked process reawaken, but free from its original mishaps.

Any form of long-term therapy, if it goes deep enough, is likely to stimulate this transference fear. What is unique about body psychotherapy is the degree to which it tends to be aroused. After all one's *body* is going to alter and develop in the thera-

py, not just one's thinking. That can evoke the aura of small-child growth needs the way little else can.

It is of course an unrealistic fear, a transference fantasy. The realistic kernel is that a transition indeed lies just around the corner, and that the therapist, as always, will have some minimal guiding functions. But the fantasy of helpless surrender to a maybe-benevolent-maybe-malevolent directing force is unreal. Even in periods of strong regressive experience and mourning and deep-level body transformation the patient remains very much in charge of what he is doing. What he surrenders to is his own inner development, not the therapist. The transference fear (and wish too) that the therapist will become like a shaping parent is nevertheless perfectly natural.

Usually the point in the therapy at which this fear heats up is some months after work with the body has been introduced. Even as long as a year after. Normally the work with the body has been going well -- which in a sense is exactly what creates the problem. The client's body is changing. And he or she wants and appreciates that, consciously. However on the unconscious level there comes the "oh oh, this is more than I bargained for." He senses a whiff of the coming more intensive transition process. And he worries in a new way about the "guardian".

This can create a rocky moment in the therapy. In supervision I call it the "crisis of existential dependency." Here too the patient may threaten to leave the therapy, or may leave in fact. Other overt behaviors usually consist of ways of distancing from the therapist. Sometimes these modes of distancing are relatively new in the therapy. An habitually wishing-to-please patient may suddenly turn intensely critical, a talkative patient may become withdrawn, etc.

In my experience this problem occurs much more often than the "sexual echoes" theme. And with a wider variety of patients. It is a juncture for the therapy because the underlying psychodynamics so frequently are outside the patient's awareness. And unlike the "sexual echoes" issue there is no way to "prepare" for this crisis. It just has to be handled when it shows up.

The key is simply for the therapist to have a good working knowledge of the nature of this crisis. She should await it in a sense; the majority of her clients won't go through it, but in principle almost any of them could. (It would be nice to have a reliable way to predict ahead of time exactly which patients are going to react that way. Unfortunately there are a lot of surprises in this area.) Then the moment she sees what might be its signs, she should begin right away to explore what is going on, using transference interventions.

A knowledge of how and when this crisis typically develops will help her pinpoint the timing. A theoretical understanding of its underlying meaning will help her articulate the right interventions.

6. *The longing for "wisdom" concerning sexuality.* This too is a form of transference possible in any type of therapy. But it becomes more likely in body psychotherapy.

If it appears, it usually does so in a later part of the therapy. It is a wish for a kind of teacher, a figure who can provide guidance in the realm of the erotic mysteries. That is not the same, by the way, as a transference wish for sexual contact with the therapist. The two wishes can be fused, of course. But even in that case, if they are to be clarified they

must be carefully differentiated from each other.

To see why this wish is more likely to come to the foreground in body psychotherapy one must understand the relevant context. This concerns a general development which takes place for many clients with respect to sexuality.

Work with the body inevitably has a strong positive impact here, in the sense that the person deepens his or her relation to his/her sexuality. He becomes more comfortable with erotic feeling, his sexual experience improves in pleasure and intensity, etc. This is true incidentally for all patients, even if at the start of therapy they believe themselves already "there" -- no problems or symptoms -- with regard to sex. To open the body is to alter contact with all affective life, erotic affect included.

All of which is a plus. Nevertheless there is a side about which the therapist must have a good understanding. At some point in the therapy (normally a fairly late point) this transition to an improved bodily contact with sexual feeling will cause some turmoil. It evokes old anxieties and conflicts, largely ones which are centered around childhood oedipal issues and which were previously unconscious.

This too is a plus. It provides a valuable opportunity for working through these old hurts and fears on a deeper level. The therapist however must be ready. Knowing this period of new sexual anxieties is likely to emerge, he or she must listen well for its overtones and be prepared to help the patient speak about it.

Along with that he must be ready as well for some new transference developments. Most of these will have the same nature as in any other long-term therapy mode. They may include wishes for

a sexually alive parent who benignly approves of the patient's sexuality; wishes for a non-sexual parent who protects the patient from sexuality; wishes to seduce and/or to be seduced; fears of seduction and fears of wishes to seduce; and fears of an oedipal punishing parent. Any or all of these may be evoked, sometimes even simultaneously. Usually they will have already appeared earlier in the therapy; now they take on a more accentuated form.

But in addition there may well show up the desire for a figure who guides, who educates, who unveils the secrets. That is a distinctive current in itself, and one which should be articulated and talked about. Disappointment and anger about what was missing in this area in the childhood past -- in adolescence as well as the earlier past -- will lie alongside.⁵

Needless to say the role of the therapist here is, as always, simply to assist the patient to explore the meaning of the transference wish. A deep and natural longing, this desire is a direct consequence of the metamorphosis the patient feels herself or himself undergoing. Her/his body is becoming a more sexual body, a more adult one. Our culture lacks shared wisdom about what that implies. The patient is encountering new questions for which she or he feels she/he doesn't even yet quite have the words.

The therapist of course should not move himself or herself into an educator position.⁶ That would be a misguided response.

⁵As will, sometimes, regret and anger also about what is missing in the culture in general.

⁶Occasionally, surprising as it may be in this day and age, the client turns out to have a remarkable ignorance of sexual basics. Rather than attempt to take over the role of a "good parent" who instructs I prefer in that case simply to recommend a self-help book. Excellent ones now exist for both

However he or she ought certainly to respect and validate the patient's quest.

Sexuality is one of life's great adventures. A part of its passion is an urge to know. The small child wondering what takes place in his parent's bedroom feels only an early version of that urge. There are more developed adult versions of the same urge, which, if the body becomes more alive, can and should awaken too.

To sum up, there definitely exist some major differences in how transference manifests itself in a body psychotherapy. On the whole, these differences brings more advantages than disadvantages. One can point especially to the area of the exploration of preoedipal transference currents. In various ways work with the body here provides substantial help.

At the same time transference in a body psychotherapy setting poses some slightly different obstacles and dilemmas. There is the "parallel roads" phenomenon. There are, with some clients, the "sexual echos" transference response; the "existential dependency" reaction; and the longing for "wisdom" concerning sexuality. The therapist must have both a theoretical comprehension of these developments as well as a good knowledge of the appropriate clinical moves which they demand.

Of course there is another kind of potential obstacle too. So far I have said little about what takes place in the therapist herself or himself. In the next two chapters I will take up the topic of the therapist's countertransference.

Chapter 23

EMBODIED COUNTERTRANSFERENCE

Vienna, the early 1920's. The eminent neuropsychiatrist Paul Schilder catches sight of a remarkable phenomenon.

Schilder (1950) is known today for having almost single-handedly created a subfield of psychological research, the study of the "body image." A still very readable book, *The Image and Appearance of the Human Body* in its earliest edition in German in 1923 stimulated wide interest.

But Schilder turned his attention in many directions. He co-directed the Vienna Neurological and Psychiatric University Clinic. He frequented Freud and his circle, and learned extensively about psychoanalysis. He co-authored a book on hypnosis (Kauders and Schilder 1922), and was generally regarded as a leading theoretician of hypnosis in that era.

He also did psychotherapy. Practicing which, one day in the early 1920's, he comes across something which nobody seems ever to have mentioned in the professional literature. He surmises that something occurring in his countertransference is being put there, is being created, by the patient.

Up to now everyone has always assumed that countertransference is strictly a product of the therapist's own past (e.g., a patient reminds the therapist, consciously or unconsciously, of the therapist's father). Or own immediate life (e.g., a patient contemplating divorce stimulates worries about the therapist's shaky own marriage). This, the form classically described by Freud, we may call *personal countertransference*. But Schilder now realizes he has sighted something else (Kauders and Schilder 1922). He is dealing in this moment, using hypnosis techniques, with a patient who is masochistic. And what Schilder finds arising in his countertransference, is reactions and feelings which are markedly sadistic. These feelings, he reasons, largely do not represent personal countertransference. Instead they have been "called forth", unconsciously, by the patient. They are responses which dovetail with the patient's feelings.

Induced countertransference we may call such a phenomenon -- i.e., it has been induced by the patient. In the world of psychoanalysis it has been a subject of much attention in recent years. It is also at times called "elicited countertransference" and/or "projective identification". (The rationale for this lattermost label I will explain shortly).

Schilder gave it no name. But he realized he had discovered something of considerable importance. He took the trouble to write about it twice. The first time was in 1922, in the book on hypnosis (Kauders and Schilder) mentioned above. The second time was in 1930, in an article entitled, appropriately, "Problems in the Technique of Psychoanalysis" (Schilder 1979, pp. 221-244). In this article, published in English in *The Psychoanalytic*

Review¹, he expresses surprise that his earlier report has aroused no stir. He concludes that countertransference is "a subject which has not yet been sufficiently treated in the psychoanalytic literature" (1979, p. 241.). What especially should be unexplored, he insists, is how the therapist's feelings can be "complements of the patient's feelings."

Complements -- one of the very terms Racker (1968) will later choose in his great treatise on countertransference.² But Schilder was ahead of his time.³ His plea had no effect, and was virtually ignored.⁴

¹The *Psychoanalytic Review*, 17:1-19, 1930. It has been republished in Schilder (1979).

² Racker came up with the word himself, however, and didn't borrow it from Schilder. Surely. Racker was particularly diligent in ferreting out examples of probable induced countertransference (unconscious reactions, with the therapist unaware of their implications) in the earlier psychoanalytic literature. Had he been aware of Schilder's comments he undoubtedly would have cited Schilder and given him due credit.

³Why was Schilder so ahead of everyone else in recognizing induced countertransference? There is a good reason, I think. It is evident from many in his writings (e.g., 1950) how extensively he trained himself to observe the on-going flux and flow of his own body experience. As I will try to show in the present chapter, this can easily give a heightened access to the nuances of countertransference states.

⁴Ignored as well was another early reference to induced countertransference, this one made in 1923 by Georg Groddeck, the Baden-Baden psychosomatic specialist from whom Freud famously took the concept of the "id". Groddeck (1949a, p. 300) remarks of a patient that, by acting like a three-year-old child, she "compelled me to assume the mother's role." His own natural tendency, he says, was to be authoritarian and "fatherly". However, this patient, and others like her, "forced" him to "adopt some other attitude." He adds: "and now I was confronted with the strange fact that I was not treating the patient, but that the patient was treating me; or, to translate it into my own language, the *It* of this fellow being tried so to transform my *It*, did in fact so transform it, that it came to be useful for its purpose" (*italics added*). Groddeck, incidentally, was also the first body psychotherapist, as I discuss in chapter 25.

Helen Deutsch (1926) in a 1926 paper also commented upon a version of induced countertransference. Her remarks equally

Psychoanalysis did wake up from its sleep regarding induced countertransference, but only in the early 1950's. At that time Paula Heimann (1989) and Heinrich Racker (1968), apparently independently of each other, rediscovered and wrote about the same phenomenon. Racker's long, searching inquiry remains one of the best upon this complex subject. Bion (1962) added interesting reflections. Harold Searles (1965, 1979, 1986), in a series of profound articles ranging from 1951 to the present day, has been a source of many valuable new insights. Of those writing in more recent years about countertransference, particularly to recommend are Bollas (1987, 1989, 1992), Hedges (1983, 1992), Kernberg (1975, 1976, 1980, 1984), MacDougal (1980, 1985, 1989), Ogden (1982, 1989, 199), and Stewart (1992). Good summaries of the historical development of the concept of induced countertransference can also be found in Slakter (1987) and Tansy & Burke (1989).⁵ As for my own point of view, it is the thinking of Bollas and Hedges to which I feel closest.

Most countertransference is a mixture of personal countertransference and induced countertransference. Naturally one main problem, when working with a patient, is to separate them out. For this one has need of two essential ideas.

The first is that what comes up in the therapist as induced countertransference is usually a piece of the patient's childhood past. What takes center stage, in other words, is what Kernberg calls a "primitive object relations unit" -- an old interactional

went unnoticed at the time.

⁵Common to these and other historical accounts in the literature is, unfortunately, a neglect of Schilder's priority in describing the existence of induced countertransference.

pattern between the client-as-child and another person in his/her ambient (mother, father, brother, etc.) This former pattern will now be played out as an interlocking set of feelings, and perhaps behavior too, between the therapist and the client.

The second idea is that the therapist, in his feelings and reactions, may find himself on either side of the old pattern. He may feel (and perhaps behave) as once did the former mother, father, brother, etc.. Or he may feel (and perhaps behave) as the client-as-child felt. The old pattern, the primitive object relations unit, is a kind of scenario with set roles for two actors. The therapist may discover he has been "assigned" either of the two positions.⁶

An example. The patient, speaking with a tone of urgency, claims on the one hand she feels desperate about her suffering, and on the other she finds the therapy useless. At first the therapist is merely surprised, especially as the patient has recently made some important gains as a result of the therapy. Gradually, however, the therapist experiences a growing despondency. She feels lonely, pressured, worthless, and incompetent.

If, however, she is accustomed to reflecting upon induced countertransference, then rather than merely submit to this unpleasant state she will begin at a certain point to interrogate it. What exactly is the feel of the induced state which troubles her? What words and/or images might describe it? What actions on the patient's side may be stimulating this state -- exactly what

⁶There can be scenarios for three or more persons as well. In the supervision of hospital treatment teams one sometimes finds that a patient has managed to replicate, in the various staff countertransference reactions, his entire family constellation.

tone, what rhythm, what body movements, what facial expression, what spoken content?

Next the therapist poses the crucial question: what ancient interactional pattern from the client's past are she and the client perhaps playing out? What is the primitive object relations unit momentarily dominating the therapeutic field? In our example the therapist might form the tentative hypothesis, to herself, that this patient has unconsciously adopted the role of a punishing, double-binding parent; and she, the therapist, has been experiencing the "complementary" (Schilder 1930, Racker 1968) feelings of a helpless, terrorized child. This hypothesis might then generate a number of additional insights for the therapist. It might also lead (examples to come shortly) to some possible transference interventions: ones perhaps to be delivered now, or perhaps best saved for later.

Looked at from this perspective, induced countertransference has tremendous value for a therapy. It is a positive happening, rather than a negative roadblock -- assuming, of course, that the therapist knows how to take the necessary internal steps for making sense out of it. Induced countertransference teaches the therapist. It shows him a movie of the patient's history; indeed puts him, the therapist, in the movie. He can learn not only new cognitive, but also new emotional information from this experience. He receives a taste of "how it was" for this patient in his, the client's, early years. Or a taste of "how it was" for a mother, father, brother, etc., in the latter's former involvement with the client.

Many years of teaching and supervising the complexities of countertransference have led me to divide its therapeutic manage-

ment into three overall practical steps.⁷ First, there is the internal perception of the countertransference state itself: sensing it, feeling it, finding words that merely describe the reactions taking place. Second, there is the intellectual sorting out: forming hypotheses about which part is personal and which part is induced; and then forming more hypotheses about what the induced part may be showing about the client's history. Third, there is a set of decisions about what to do with any new information thus learned. Should one now intervene, directly or indirectly referring to the one's internal state? Should one keep silent? Should one use the new insights to think out other possible transference interventions which could be useful later down the line?

Surprisingly, *the first of these three steps, the awareness, the conscious perception of the countertransference state, is the most difficult one.* Not that any of them are easy. Countertransference can be a labyrinth, a maze of potential confusion at any point. But simply to be aware that it is occurring, and simply to absorb and notice the details of the emerging inner state itself, is the hardest part even for experienced therapists. *One property of the very nature of countertransference seems to be a dulling of the therapist's sensibility.* Even if prey to strong emotions, she or he often feels them in only a diffuse, global manner. One tends to avoid letting the experience take on sensory precision.

Hence the potential usefulness of what I will call embodied countertransference. I mean by this a mode of confronting and perceiving countertransference, a practical way of giving it more

⁷Tansy & Burke (1989), in a good discussion, subdivide the confronting of countertransference into even more steps.

internal room in the therapist's consciousness. The reports of many therapists who have learned this approach have convinced me that the body truly has here a unique role to play.

One could say, of course, that all countertransference is embodied from the start. Meaning, that states of countertransference comprise not only thoughts and/or images about the patient, but also, always, some form of bodily reaction. And this is certainly correct. I intend the term in another sense, however. Yes, some degree of bodily reaction is always there, however dimly perceived. But usually this bodily level is slighted by the therapist. She evades it, ignores it. She turns her attention anywhere else. At best she notices a bit, but then fails to let it more fully develop.

I advocate following a different road. To allow countertransference to become embodied entails that one places a higher value on this bodily substratum. One gives the emerging physical reactions more inner space, one permits them to unfold, one subjects them to a patient, slow interrogation. The therapist who works with embodied countertransference knows that his or her body can function as a channel. He knows it can be a source of new discernment and insight which otherwise might rest obscure.

Any therapist can do this, and in conjunction with any kind of therapy. One does not have to be a body psychotherapist. It is simply a matter of cultivating, over the years, this usually much neglected mode of access.

I also don't mean to imply, let me hasten to add, that a utilization of the body for a fuller grasp of countertransference is entirely new. Some of the literature in fact already mentions it in passing. At the same time, however, what has been commented upon so far remains rather limited. On the whole what we

usually find reported is that the therapist has noticed some momentary bodily discomfort; and then, tracking his associations, has made a countertransference inference.

Here for example is Bollas, responsible for some of the best writing on countertransference currently being produced. He notes,

For example, it came to my attention one day that while with a particular patient I was holding my breath. I was not breathing properly. I was tense and felt all bunched up inside. On further consideration I realized that much of my interpretive work had come from my bunched-up soma....I may ache from psychic pain affecting soma, and my interpretation will come from there -- the ache. Or a patient may be so overwhelming, my anxiety so high, that I am more a creature of my respiratory system, so that some interpretations will evolved out of this somatic distress....

I seem to be saying that analysts are mediums for the *psychosomatic processing of the patient's psychic-soma*. And that we "find" different patients in different locations depending on how we are unconsciously invited to process them. I may be working with someone in my soma -- in the stomach, the back, or in my respiratory system.....

(Bollas 1989, p.58. Italics added.)

This is typical. And it is excellent as far as it goes. But embodied countertransference can inscribe itself in more than

aches and pains.⁸ And the use of the therapist's own body as a perceptual instrument can range far beyond the registering of physical distress.

A rare exception to this emphasis on momentary physical discomfort is a fine article by Speziale-Bagliacca (1991a).⁹ He makes the radical suggestion that a key to better perception of countertransference can be for the therapist to tune into his or her own breathing. And to stay with his breathing, in the margins of his consciousness, while he listens to the patient's discourse. This is exactly right, in my opinion. By this and by a number of similar means the body can supply a flow of additional subtle signals. At any moment which seems appropriate, moreover, these signals can be allowed further amplification.

Speziale-Bagliacca also adds the excellent point that to bring the body into play in this fashion implies a special relationship to time. Often when one tracks the therapeutic dialogue on a body level, there must be a gradualness, a slow registering of successive increments. One has to wait while something builds itself up in the body. Speziale-Bagliacca shows how, when a therapist moves too hastily from a first sensing of a countertransference state to a cognitive conclusion about its meaning, the chances of error become greatly increased. Too little data

⁸Exactly as one would expect from this more general statement by Bollas: "It is well to bear in mind that often a patient's instinctual drives seek a route to mental representation through the analyst's soma, given that the patient trusts the reliable link between the analyst's soma and psyche" (1989, p. 59).

⁹Concerning the body and countertransference, also to recommend is Jacobs (1991, pp. 101ff.). And, from a Transactional Analysis point of view, Lammers (1992). Krueger (1989) also makes much the same point I am suggesting here when he proposes "the therapist, essentially, can learn to listen with his or her own body" (p. 50).

is being utilized for too large a jump of reasoning. A better option would have been to keep in touch with the body reactions, and then slowly, with patience and awareness, to allow a more differentiated inner state to form itself.

Breathing. The flux of corporeal sensation. Urges towards movement. Shifts of posture. Tendencies to make a gesture, or the actual making of one. Rhythms of speech and tones of voice, independent of verbal content. Qualities of inner space within the body; qualities of denseness, of floatingness, of unity or its lack, of connectedness or disconnectness. Pleasure, light ripples or intense waves of it. Discomfort, twinges, itchings, pains. Emotions of all sorts in their immediate and precise body manifestations. This is a universe in itself, and one can learn how to let it be more present to consciousness. One can learn how to listen to and observe the client, and yet simultaneously live a little in this parallel body universe. Guaranteed in that case: a heightened access to many of the more elusive overtones of your patients' stories. Guaranteed as well, it is certainly worth mentioning: the practice of therapy will become a still more engaging activity.

One tracks this flow of body events, according them for the most part only a marginal consciousness. Then, when the body wants to speak up more strongly, it will be as if a red warning light has flashed a signal: something worth closer attention is stirring. One gives more focus in that case, like using the zoom lens on a camera. The bodily state can then unfold, manifesting itself with an increasing distinctness.

Along with this one can look for words, but at first only descriptive ones: "this heaviness...it is as if my arms won't work, can't function...as if even if I wanted to I could never

reach out towards the other person...." Essential is try to remain unhurried (often not easy, especially if a degree of panic or pressure are showing up as part of the state itself), and to try to tolerate some long moments of ambiguity (also often not easy). That will give room to the necessary back-and-forth between body experience and descriptive language.

To repeat, all of this, both the slow sensing and the searching for a first level of descriptive words, is prior to a cognitive sorting out of what the countertransference state might actually mean. Naturally at times the intellectual understanding will also come at once, in a flash, as if one has been handed a tidy package. But often, when possible, it is better deliberately to wait before making things intellectually too clear. Therapy sessions are spacious. There is time to let the experience itself go through some twists and turnings.

What, practically speaking, does one do with what has been learned from examining one's countertransference? *Countertransference-based transference interventions* can be at times an effective follow-up. Naturally the therapist must have first separated out, for himself, what he suspects is personal countertransference and what is induced countertransference. Then the part which represents induced countertransference can be used as a source of specific interventions.

Here one option is what is known as direct disclosure. The therapist simply tells the patient about what he, the therapist, has just experienced, or tells him some portion of this; and next invites the client to explore with him what that experience might be saying about the dynamics of their relationship.

For my own part I am not a strong partisan of direct disclo-

sure, however. I use it once in a while, but not often. Direct disclosure, I find, though it has certain advantages (e.g., it models how inner states can be shared), frequently runs the risk of an excessive intrusion of the therapist's person into therapeutic dialogue. Let me add that there exist good counterarguments to what I am saying. Some therapists -- Bollas (1987, 1989, 1992) is an example -- rely extensively upon direct disclosure, and feel it to be a reliable and versatile instrument.

What has served me well, and what I employ rather often, is indirect disclosure. It works like this. Take our example from before, the therapist who was feeling more and more despondent as the client berated and criticized the therapy. We already saw how she, the therapist, might hypothesize, silently, that something from the patient's past, an old object relations pattern, was being replicated in both the transference and the countertransference. The patient was now, according to this hypothesis, taking on the role of a punishing, double-binding parent; and the therapist, the role of a desperate, double-bound child.

A simple intervention for immediate use might therefore be as follows.

You seem to be desperately asking for my help
and at the same time telling me that nothing
I could possibly do would be of any help to
you. Could it be that a part of you wants me
to feel pressured and helpless? What do you
think?

Notice how this intervention refers to the inner state of the therapist, but only indirectly. It makes an efficient use of the private information without the potential complications connected

with direct disclosure.

An intervention working a little farther "down the ladder" might include a hypothesis about the underlying intent of the transmission of feelings. Perhaps in the next session a similar dynamic appears to be taking place. The therapist might then comment so:

Again today you seem to be acting as if you wanted me to experience a lot of helplessness and pressure. I have the phantasy that perhaps these feelings are similar to things you felt at times as a boy. Perhaps what is going on between us now may even be a way of your showing me what your experience was like sometimes back then. Is this possible?

This intervention of course assumes that, in the therapist's judgement, the patient might be ready to take at least a glimpse at the links between his present behavior and his childhood past.

A related point. Both Kernberg (1984) and Meissner (1984) have made the following useful observation. If one day the therapist finds himself, in his countertransference, at one pole of an old "object relations unit," he can virtually count on the likelihood of finding himself in some later session (or even minutes later in the same session) at the other pole.¹⁰ If, in the example above, he is in a "victim" position which has particular nuances, then at some later point he will discover himself in an "aggressor" position having the complementary qualities.

The same object relation unit, in other words, will probably continue to re-emerge, but with switches and variations. To know

¹⁰Rapid pole-to-pole switches in the same session are especially typical of highly disturbed patients.

this is helpful. The therapist can be prepared, within herself, for the "opposite pole" countertransference. And when it arrives, she can then all the better use it to generate still new transference interventions.

I will now take up a somewhat knotty and difficult technical point. But it is an extremely important one, I find. It concerns the *exploration of multiple motivations* for the creating of induced countertransference.

Why is it that a patient "transmits" these induced states? Why does he or she "put" projective identifications into the therapist? What is the aim, the goal? What is his or her unconscious up to?

In several previous chapters on transference I have already stressed what I call a "wide-angle" approach to the understanding of hidden transference motivations. The idea, you will recall, is that most transference behaviors have multiple unconscious causes, just as dream symbols tend to have multiple levels of disguised meaning.

The same motivational complexity is present in the transmission of induced countertransference, I believe. What we have here at bottom is a very special transference "behavior" on the part of the patient: the behavior of stimulating and evoking certain reactions in the therapist. And like any other significant transference behavior, its motivational sources will usually be several.

The therapist's interventions can profitably reflect that fact. Consider again the example just given above. I will repeat the same words of the last intervention, this time italicizing the therapist's hypothesis about underlying motivation.

Again today you seem to be acting as if you wanted me to experience a lot of helplessness and pressure. I have the phantasy that perhaps these feelings are similar to things you felt at times as a boy. *Perhaps what is going on between us now may even be a way of your showing me what your experience was like sometimes back then.* Is this possible?

So here the proposed hypothesis, offered for the patient to explore (or modify, confirm, disconfirm, etc.), is that her unconscious intent was a highly positive one. Her unconscious intent, according to the hypothesis, was to present the therapist with a movie of her, the patient's past. Her motivation was to transmit information in a nonverbal way, and thereby to be better understood.

But is this the *only* likely motivation? I doubt it.

Let us take a step back for a moment. What does the literature on induced countertransference tell us about this question of motivation?

Well, at first glance the literature tells us both too little and too much. In fact, at very first glance -- i.e., for the reader for whom the current psychoanalytic reflections on induced countertransference are totally new -- the literature is downright chaotic. Each author seems to have his or her own favorite definition of the phenomenon (and this independently of whether the label being used is "projective identification" or "elicited countertransference" or some other name). Each seems almost to be tracing the outline of a different animal -- "too many different things [being described] by too many different people under too many differing circumstances", as Kernberg

(1987, p. 93) remarks.

This seeming theoretical chaoticness takes on more order, however, when one looks at it from the point of view of motivation. It is not so much differences of definition which create the aura of confusion; it is differences in the accounts of motivation. Why, to repeat our query, do patients unconsciously create special states in their therapists? Answers abound. Whoever tackles this issue will have her or his own guess, and the guesses are many.

My own sense of why that should be -- this is really my own guess, in other words -- is that the unconscious intent causing induced countertransference is multiple in nature. The patient's goals are highly, are intricately, overdetermined. Whence so many seemingly contradictory accounts in the various theories. This occurs because different authors tend to zero in on different subareas of motivation. Any single account may be full of insights as far as it goes, yet it is likely to fall short of recognizing the full complexity of the mobilizing causes of induced countertransference.

Take, for example, the original concept of "projective identification" as it was first introduced by Melanie Klein (1976). Writing in 1946, she meant by this term merely to denote a defensive phantasy on the part of the patient. In this phantasy, which of course may be unconscious, he, the patient, imagines first that unwanted affects or self-parts of his own have been deposited in the therapist. And next he imagines that, by acting in a controlling manner towards the therapist, he, the patient, is effectively keeping at bay the dangerous "projected" feelings

or self-parts.¹¹

Now this is a very helpful concept. Klein herself said nothing about any corresponding countertransference experience on the therapist's side, but her followers (e.g., Bion 1962) soon expanded the notion to include this dimension as well.¹² (Modern uses of the term "projective identification" thus usually refer to induced countertransference.¹³)

It is of course a rather negative picture of the patient's intent: his motivation is here seen as a purely defensive one, a (in his phantasy) getting "rid" of, an "evacuating" of something which disturbs him. But on a practical level, if one intervenes with patients using this sort of hypothesis, one quickly discovers that it sometimes opens doors. Many clients find it helpful. "Perhaps your purpose in doing this [i.e., stimulating such-and-such a countertransference state in the therapist] is to try to get rid of feeling X. Perhaps the idea of putting feeling X over here into me gives you a sense of being more free of it, or more able to manage and control it. What do you think about this?"

More generally speaking, a patient often can have simultaneously negative and positive unconscious purposes for triggering

¹¹One could of course question both whether 'projection' and whether 'identification' are labels which really apply here. The phrase "projective identification" itself is a piece of language with which few find themselves completely comfortable. Even Klein eventually became dissatisfied with the term, although she and many others decided simply to live with it.

¹²For her own part Klein remained cool to the notion of projective identification as including the therapist's own experience, even long after this sense of the term had been circulating in the Kleinian professional circle.

¹³Usually but not always. On occasion it is Klein's original idea which is meant, a one-person event just taking place within the client, rather than the two-person event of induced countertransference. For a good more extensive discussion of these differences see Meissner (1987).

induced countertransference in the therapist. Or so I am convinced. The therapist will find it quite useful to explore both these sides (though not necessarily in the same session).

Some of the negative, i.e., defensive or protective, purposes can be as follows. To control an unwanted self-part. To create distance in the therapeutic relationship. To make the therapist ineffectual so as to reduce envy. To hang on, by re-creating them, to childhood pathological relationships, thereby avoiding loss, change and/or the unfamiliar. To give the patient a safe target for discharge, during the sessions, of contempt or anger or other difficult feelings which would be dangerous for her or him to discharge elsewhere. (Every one of these purposes, by the way, has been highlighted by one or another of the various theories about induced countertransference¹⁴).

Some of the positive purposes can be these. To inform the therapist about states the patient is not yet able to verbalize. To inform the therapist about the patient's childhood past. To protect a positive self-part, such as the ability to set limits with oneself, by "throwing" it into the therapist (thus here stimulating the therapist to set limits, e.g. about acting out, which the patient himself or herself is unable to do). To test that the therapist will not act out in ways a parent acted out. To re-create a formerly negative situation (by replicating an old family interaction) in the hope of having this time a new, more positive outcome. (Every one of these purposes too has been accented by one or another theory.¹⁵)

¹⁴C.f. for example Kernberg (1975, 1976, 1980, 1984), Klein (1976) Meissner (1987) and Sandler (1987).

¹⁵C.f. for example Bollas (1987, 1989, 1992), Hedges (1983, 1992), MacDougal (1980, 1985, 1989), Ogden 1982, 1989, 199), Rosenfeld (1987) and Stewart (1992)

All of these motivations are possible to explore through transference interventions. Especially if a patient seems to be repeatedly evoking, session after session, a particular set of countertransference reactions, it can be a good idea to approach her or his intent in doing so from a number of different angles. The therapist can suggest one possible hypothesis about motivation in one session, another hypothesis in another session, and so on.

Locating the double hook is another important step when the therapist examines countertransference. Normally also it is a silent step, a thinking though which is not shared. But whenever the countertransference experience in question is one of significant proportions, this step should not be neglected, in my opinion.

I have in mind, for example, a countertransference state which frequently reappears in the work with a particular patient. Or a state which is unusually difficult, thorny, overwhelming. Or, above all, any constellation of reactions which appear to be contributing to an impasse in the therapy.

Here is what I mean by the double hook. A patient often has a need, during some phase of the therapy, to replicate some painful or unresolved situation from his past. This need is the hook which comes from the patient. In order to reproduce the former situation she or he requires, unconsciously, that the therapist feel and possibly even act in some particular way.

But a second hook comes from the therapist. Unconsciously the therapist will rummage about, so to speak, in his or her own past, and come up with something more specific from that history which nicely corresponds to the replication needs of the patient.

The two respective pieces of autobiography, the two hooks, interlock. They mutually reinforce and modify each other. Jointly they create the double hook.

I could give many examples. Here is one from a case I supervised. A woman patient developed an intense homosexual attraction to her female therapist early in the therapy. Her feelings were both erotic and romantic; her behavior, in conveying these sentiments, was also distinctly controlling of the atmosphere of the sessions. Unconsciously this patient was replicating, partially, a history of sexual abuse. She was putting the therapist in her own former victim position.

But in turn this projective identification drew out a charged piece of personal history from the therapist's childhood. The therapist had had an older brother who had been the one positive figure for her in an otherwise highly pathological family constellation. It had not been easy for her to maintain this brother's interest in her, however. The only way had been through flirtation and sexual innuendo, a kind of delicate dance at the brink of danger. She had managed to keep her brother attracted without ever pushing their relationship into an actual sexual acting out.

So around in their infernal circle they went, patient and therapist. The one complaining, wooing, pressuring, controlling. The other tormented yet aroused, imprisoned in a kind of trace, sending double messages right and left, consciously rejecting the other's seduction but at the same time unconsciously encouraging it. The double hook was in operation; exquisitely, as often is the case in a serious impasse. Other unconscious motivations were also present on both sides, as we were able to surmise. But the ones just described were the most visibly dominant.

Frequently a therapist is surprised, if not abashed, to discover, in supervision, how neatly some element of his own history has intermeshed itself with elements of the patient's past. A not uncommon reaction is "What, that? This old conflict, this old pain, yet again? I thought I had worked that out in my own therapy!"

But this reaction misses the point. It may well be that a particular theme from my childhood has been dealt with, and rather thoroughly, in my own therapy. As well as in my own continuing work with myself. Yet it can still happen that one particular patient "pulls" this theme forward as a device for replicating what needs to be resolved from his, the patient's, own past.¹⁶ My theme and his theme then become mutually reinforcing, like magnets locking together. This is the power of the double hook.

Of course it can also happen, and all too easily, that what the patient draws out from my own past is some conflict, some constellation of emotions, which, far from having worked though, I have successfully avoided and denied over the years. This can be true, at times, for even the most seasoned therapists. In which case the strength of the "hook" from my side may become formidable indeed. When that occurs, some inner (i.e., private) clarification of what has been activated from my autobiography will likely be indispensable if the therapy is to progress further. Yet even this situation does not imply -- and one cannot emphasize this too much -- that there is no significant induced countertransference being sent my way by the patient. On the contrary, several layers of extremely relevant induced counter-

¹⁶C.f. especially Bollas (1989) and Hedges (1992) for thoughtful discussions of this point.

transference may also be present, simultaneously. And may also need to be grasped, elucidate, explored. Again, the double hook.

Listening to the indirect commentary is a technique which has already been discussed (chapter 20) as a helpful means of formulating new transference inventions. But it also needs to be mentioned with respect to countertransference.

You will recall the basic principle. The patient's discourse profitably can be listened to on two levels at once (Langs 1977, 1978, Casement 1985). One then looks for metaphoric, indirect references to the therapist and the therapy. For example, when asked directly about his feelings about the therapy, perhaps the patient says everything is fine, he is quite pleased and optimistic. Then, changing the subject, he talks about his connection with a current girlfriend: he is worried that she will surely leave him if he openly reveals his many negative feelings about aspects of their relationship. Here, probably, the coded message is that this patient unconsciously perceives the therapist as likely emotionally to withdraw if he or she, the therapist, be confronted with criticism about the therapy.

Now that can be valuable information for formulating a transference intervention. But it can also give a perspective for looking at countertransference. In this example the therapist would ask herself or himself: to what extent is this patient's unconscious perception true? In what ways am I, with this patient in particular, more sensitive to criticism, and/or more ready to punish by making myself distant? Such unconscious perceptions coded in the patient's discourse are to consider seriously. On occasion they are wholly off target, but plenty of

other times they contain a kernel of truth.

Once the therapist has a hunch, after having listened to the patient's commentary, that perhaps more elements of countertransference are at play in her behavior than she had thought, then she is in a good position to return to her body experience. In this example she would next pay acute attention to how with her body (e.g. by stiffening at certain moments, or changing position, or deflecting her gaze, or deadening her breathing, etc.) she may in fact be distancing from the client on a subtle level. The patient's metaphoric message will have guided her. She will have been warned, so to speak, about what to watch for.

Of course the coded commentary also has its limits. Typically it says nothing, for example, about what might be personal and what induced countertransference. The commentary just points a finger at facts of behavior: the therapist's intrusiveness, or coldness, or states of confusion, or seductiveness, or authoritarianism, or forgetfulness, etc. The commentary says: look at what is actually going on here, according to my, the patient's, unconscious perception. But, if the therapist in reality is having states of confusion, or is acting authoritarian, or whatever of the like, this could be for different reasons. That is open. What she or he is doing might largely reflect induced countertransference (e.g., her or his states of confusion are replicating something of the patient's psychotic father). Or it might largely reflect personal countertransference. Or it might be the result of a tightly dovetailed mix of induced and personal, a double hook. This remains for the therapist to sort

out.¹⁷

Preverbal transactional patterns can sometimes be reproduced as a combination of transference and countertransference. The therapist should be alert to this possibility. If it happens, he will discover that his own body and the patient's body are engaged in repetitive nonverbal maneuvers of some singular kind. It may then be the case that some pattern which was typical in the patient's earliest preverbal interactions with a caregiver is now being replicated in the session.

An example. I was supervising a female therapist who felt that her work with a male patient had reached a stalemate. In the therapy they had talked at great length about the patient's feelings of abandonment. He was convinced that his mother, when he was an infant, had deprived him of all essential contact, physical and emotional. His image of the lack belonging to his early past was an image of stark physical aloneness. The therapist too had accepted this picture.

But in the supervision a curious fact came up. I had asked her, as I often do, to talk about her body experience when working with the patient. She remarked that in the last two or three months she could "never sit right". We went more into this. It appeared that during the recent weeks she was perpetually shifting, turning, twisting, re-arranging herself. She would start to settle into one posture and then find herself hunting in her body

¹⁷In my opinion this is the step which is missing from Langs (1977, 1978) otherwise superb analyses of countertransference. Langs uses the coded commentary to pinpoint what in the therapeutic frame is missing or wrong or out of order. But he never raises the question of whether the source of the problem with the frame is induced or personal countertransference.

for another one. The emotional quality of this squirming and repositioning was one of disquiet, mild frustration, and guardedness.

After paying closer attention to this process in the next two sessions she was able to clarify how her own body movements seemed to be interlocking with the movements of the patient. Each time she started to get comfortable in her position he would alter his position. Instantly it was then as if she had to move again; it was as if there was something imperative in how he arranged his body. He even would often look at her sternly, "as if giving a command". She became aware how greatly she felt intruded upon and physically manipulated in this nonverbal scenario, as if she were a puppet or a toy or a corporal thing.

What this eventually led us to was a new hypothesis about this patient's preoedipal history. The induced countertransference was suggestive of how the patient himself may have felt during the preverbal epoch. While assuming there must be some important truth to his preoccupation with abandonment, the therapist began exploring as well whether the patient's mother (the only caregiver) had not also been strongly invasive, physically controlling, and overinvolved with him but in a highly insensitive manner.

The opening up of this theme produced a turning point in the therapy. A series of dreams provided considerable support for the hypothesis. The transference relationship also became more alive. Although in this period of the therapy no work with the body had been undertaken, later on, when that became possible, the therapist found additional confirmation of the same hypothesis. Body regressive states having to do with intrusion and insensitive controlling emerged much more frequently than states

suggesting an ambiance of abandonment.

It seems probable that the patient had unconsciously "chosen" to re-enact, in the transference relationship, precisely what at this point of the therapy (i.e., at the time of the original supervision) ought to have been examined, but in fact was not being examined. That is a frequent reason, I am convinced, for the timing of a replication. Something of import is being omitted, and perhaps glaringly so, from the explicit therapeutic dialogue. So the unconscious of the patient arranges that it come up anyway through this alternative means.

What, with respect to countertransference, is special or different in body psychotherapy? So far I have been talking about countertransference in general, as it might be encountered by a therapist working with almost any type of methodology.

For the most part, countertransference in body psychotherapy is not very different. Induced countertransference and personal countertransference show up neither less nor more than in most therapy modalities. The same impasses, confusions, and stalemates can result. What the therapist must do, to decipher and resolve her/his countertransference barriers, also is largely identical.

The principal factors I see as different are three. Of which two can be stated quickly.

First, as I have said, any therapist can cultivate the instrumental use of embodied countertransference. There is nothing esoteric or mysterious about this mode of access. However, a body psychotherapist tends to have an easier time acquiring those skills, at least in the beginning. The reason is that to tune into body signals and body events is simply more familiar.

The body psychotherapist is used to this from his or her own therapy experience as a client, and is also used to helping his or her clients do the same. Certain patterns of attention are already in place. The application of this awareness to the understanding of countertransference is therefore less of a jump. Just as important, the body psychotherapist will know a rather detailed theoretical framework for comprehending many body phenomena which might otherwise seem inexplicable or opaque.

Second, the work with body regressive states in a therapy gives a form of cognitive information about the patient which would be more difficult to gather by any other means. This information, as discussed in previous chapters, concerns the patient's probable preoedipal history. The principle use of such hypotheses, of course, is for the patient's own grasp of his past. And another use, described in chapter 22, is for the generation of new transference interventions (i.e., a better knowledge of dynamics from the past can help make more sense of present transference behavior). But still another use can be for an understanding of certain induced countertransference states. Occasionally, as we have seen, induced countertransference will reflect very early interactional patterns from the patient's history. If work with the body has already been begun in the therapy, then the deciphering of these induced states is often easier. One has a context of information, a frame of reference, to apply. And even if the use of physical techniques has not already been begun (as was the case in an example presented shortly above), there remains the small advantage that hypotheses about induced "preverbal" countertransference are more likely to be confirmed or disconfirmed later on.

These are both positive differences. They reflect particu-

lar strengths of body psychotherapy. The third factor is the opposite. It has to do with several points of vulnerability in body psychotherapy.

In my opinion every therapy modality, bar none, has certain special areas of potential countertransference impingement. These are aspects of the method which can easily lend themselves to countertransference-based errors. They are like the curves on a highway where one must be more than usually careful how one handles the car. Body psychotherapy is here no exception. In the next chapter I will discuss this other side.

Chapter 24

SOME COUNTERTRANSFERENCE TRAPS

All therapy methods have their special points of countertransferential vulnerability. These are areas where the therapist should be particularly attentive. They more easily lend themselves to countertransferential confusions and errors; they are potential "traps" to be guarded against.

What are the possible traps for body psychotherapy? From my experience doing supervision, there are three which stand out.

Overinvolvement in the therapeutic symbiosis. I have already talked about the positive therapeutic symbiosis. (The term is from Searles (1965), c.f. chapter 22.) This is an intermittent heightened closeness between patient and therapist which can take place in the middle stages of the therapy. Can and should; it is an enriching, healing connection. Healing chiefly for the patient naturally, but in a tiny way for the therapist too (as Searles points out.¹) The fact that work with the body has the

¹A theme which Searles (1965, 1979, 1986) has taken up repeatedly.

potential to lead to a more profound therapeutic symbiosis is one of its important sides.

Nevertheless the therapeutic symbiosis also has the potential to create countertransference difficulties. One which can especially cause a problem is overinvolvement. By this I mean that the therapist is excessively attached to the symbiosis.² His or her own needs and desires are too much in play. He loves the symbiosis, he feels alive when he is bathed in it; and as a consequence he doesn't want to let it go.

Which makes for trouble. Because sooner or later the patient will want to disengage himself from the symbiosis. And that is appropriate; it is what must happen if growth is to continue. The patient individuates, he feels out new modes of autonomy, he begins to shed his therapeutic dependency. A therapist who is overly attached to the symbiosis may have a hard time permitting this, however. She may find a hundred ways to block and sabotage the steps toward individuation. The symbiosis (or at least an attenuated form of it) is artificially prolonged. The patient on an unconscious level has only two choices: either prematurely to quit the therapy, or to join the collusion.

I will recount a particularly impressive example. A therapist came to supervision for help with three cases. In all three he felt he was running into a similar problem: therapeutic progress seemed to have reached a plateau, i.e. the patient was not changing any more in his outside life -- yet the therapy sessions themselves were going "beautifully."

Supervisory investigation uncovered the following factors.

²Naturally underinvolvement -- blocking or excessively distancing from the therapeutic symbiosis -- can also be a difficulty. But more common in a body psychotherapy setting are problems with overinvolvement.

The therapist tended to insist that patients who had been a while in therapy systematically enter cathartic states. A lot of "hard" body work together with overactive encouragement helped promote these states. After much affect expression the patient was then routinely told to "find out what you still need." This almost invariably elicited a request for supportive body contact, for example that therapist hold the patient's hand. A patient who didn't come up with some such request was likely to find himself being politely interrogated about why at the moment he or she had anxieties about "receiving."

Underlying these technical errors (pushing too hard, overdirectiveness, lack of more nuanced work with affect, overly automatic use of supportive contact, confused messages about whose need for contact was really at play) was a more general "addiction" to intense emotional symbiotic connectedness. By altering his technical practices, as well as re-entering therapy himself in order to resolve some conflicts from his own history which underlay this need, this therapist in the succeeding year was able in a major way to improve the quality of his work.

Avoidance of mourning. This has been a problem for more body psychotherapists than I initially would have expected.

It is a tricky issue. You would think that, whatever her/his other countertransferential difficulties, a body psychotherapist would be fully at home with a mourning process. After all, work with the body elicits affect. Emotions of all kinds sooner or later make their way to the foreground, the full spectrum of sadness included.

However a mourning process is something other than just intermittent experiences of sadness in a series of therapy ses-

sions. A mourning process is deeper, and more complicated. It takes place more outside the sessions than during them. It is a living very close, for an extended period of time, to a whole constellation of feelings: sadness, regret, guilt, outrage, yearning, and a kind of patient thread-by-thread inner letting go. Simple experiences of sadness and/or crying during a session, while often of value in themselves, are not an equivalent.

A therapist can easily have her or his own inner resistance to allowing a mourning process to take place in therapy. One cause, for example, can be unconscious unresolved mourning in her/his own person. This is of course a common problem, one hardly special to body psychotherapy.

More particular is what some body psychotherapists end up doing with it. Here we find a vulnerable point belonging to a body psychotherapy methodology.

When working with the body it can be all too easy, should the therapist wish this, to arrange matters such that, fairly consistently and regularly, the patient at the end of the session *feels good*. Hugs and smiles -- frequent exhortations about bodily vitality -- nonverbal rewards, late in the session, for reports of pleasurable states but not for reports of others -- an overuse of supportive physical contact -- there are a lot of possible strategies. (Which may in themselves be unconscious or quite conscious.) Their combined effect is to send a powerful covert message: if you are responding in the right way to what I am doing for you, then once the hour ends you should feel tip-top. The subtle pressure which is thereby created can be enormous.

And, however well meant, it does not benefit the patient. The real job is simply to help the patient open up to whatever at

the moment is inside him/her. Feelings of pleasure or of pain; of vitality or of depletion; whatever. And then to permit him/her to leave the session with this feeling process still in inner movement. This is independent of whether the patient "likes" the feelings. Or for that matter of whether the therapist "likes" them either. Otherwise the therapist and patient are likely to form what Langs (1978) calls a "bastion" -- a walled-off thematic area which the therapy systematically passes over.

Particularly this can happen with mourning -- i.e., with a extended mourning process as described above. Then, in a supervisory context, one may discover what seems at first so paradoxical: a therapy in which all feelings, sadness too, are expressed, yet mourning in the sense of a deeper process is blocked. The patient's need to mourn has been sealed away in a bastion.

The lure of grandiosity. If body psychotherapy has an occupational hazard, this is it.

Do therapists using other therapy forms develop problems with grandiosity? Certainly. Plenty of them. But there is an aspect of body psychotherapy which can easily reinforce whatever tendencies a therapist already has in this direction.

It is the discrepancy between, on the one hand, the technical ease with which a body process can be stimulated; and, on the other, the power and complexity of the body process itself. So little triggers so much. That can make for illusions. And on both sides of the therapy relationship.

The patient, baffled from discovering how much has stirred itself up in him, will tend to idealize. He may see the thera-

pist as the possessor of a kind of magic.³

And the therapist in his turn...you can see the problem. On the one hand here is the fact, the real concreteness, of the patient's bodily reactions -- brought about at least in part by one's own expertise. On the other hand here is this stream of gratitude and admiration coming one's way. What more natural than to feel tempted to mystify the situation a little?

Every body psychotherapist needs to work out thoroughly his/her countertransference reactions to this one.

Plenty of other countertransference problems can take place in a body psychotherapy setting, naturally. I have focused here upon several which I see the most often.

What, incidentally, most frequently causes a therapist to stumble into one of these countertransference traps: induced or personal countertransference?

Either one. Or both in combination. This needs to be well understood.

The traps are merely points of vulnerability belonging to the method itself. Take, for example, the trap of overinvolvement in the symbiosis. The method merely creates an opportunity for that potential error. But when a therapist actually does, in the treatment of a particular patient, get overly attached to or needy of the symbiotic connection, there will be more specific reasons in operation. Perhaps these will

³This trap can become still more acute in workshop settings. In a therapy setting the patient will usually leave behind this particular type of idealization fairly early. Repeated experience working with the body makes apparent to him that what sometimes emerges has to do with his person and body, not with the therapeutic tools. Whereas participants of workshops may not have the opportunity to get beyond their initial impressions.

have chiefly to do personal countertransference: e.g., this client is somehow like the therapist's mother, with whom the therapist had a hypersymbiotic closeness. Or the reasons will concern mainly induced countertransference: an extremely symbiotic tie the client once had to a sibling is being replicated in the therapy. Or both forms of countertransference, a double hook, may be in play.

It is important that the therapist comprehend this last point. Otherwise one might think: this method which I practice, it has its potential traps, but they don't concern me, I have done my homework, I have resolved enough of my problems, these are traps likely only to catch others.

Wrong. Misplaced arrogance. Because, as we saw in the last chapter, induced countertransference too can always exert a powerful sway. Plus, induced countertransference can also be a magnet for even the most "resolved" issues from the therapist's own past.

Therapy is not an easy *metier*. Every one of us who practices it is constantly buffeted by her/his own unconscious currents. The antidote is inner awareness, self-confrontation, and listening well to the messages coming from the patient. Otherwise we set unnecessary limits not only upon the patient's growth but also upon our own.

Chapter 25

A BRIEF HISTORY OF BODY PSYCHOTHERAPY

Body psychotherapy has had a long evolution. Historically its roots go almost as far back as psychoanalysis itself. This story will someday be told with the fullness it merits, one hopes. I mention here only several highlights.

Freud

Freud at one time massaged his patients. That is less strange than it may sound. In the late nineteenth century persons suffering a "nervous crisis" were often prescribed a "rest cure." Translated, that meant a trip to a spa, some days or weeks of inactivity; and, usually, frequent massages. This hands-on work might well be done by the physician in charge of the treatment. Freud was following an established procedure of his time.

Curiously enough, the actual beginning of psychoanalysis proper occurred *during a massage*. This was the first session,

Freud tells us, in which he tried out the technique of free association (Breurer & Freud 1893, p. 56.)¹ Throughout the session Freud was massaging the patient, a woman (Frau Emmy von O.). Simultaneously, as was then his habit, he did verbal therapy. Only instead of working with hypnosis, which up to now had been his usual undertaking, he chose to let her free associate. She managed to do so quite productively. The psychoanalytic movement was born.

It would be easy to read either too much or too little into this amusing historical fact. On the one hand we find here the working of chance rather than destiny. For Freud the practice of massage had no intrinsic tie to his quest for a new methodology. He was headed elsewhere; massage would soon be left behind. Nor would it be replaced with something equivalent, in the sense that free association replaced hypnosis. From start to finish Freud's interest, technically speaking, was in the word.

On the other hand if we move to the level of Freud's metapsychology there is somewhat more to say. In Freud's theoretical point of view -- always changing, always in movement -- the body remained a question and a subject of inquiry. He never treated it as an obvious, simple given.

You wouldn't know this from reading about Freud. His commentators (both psychoanalytic and academic) usually tell us he stood for "nineteenth century materialism" in its classic form -- mind reduced to body, the latter understood as a biochemical machine, etc. But that is a serious oversimplification. True, Freud started out with a straight-forward version of the materi-

¹The two pillars of psychoanalysis are often said to be the use of free association and the analysis of the transference. Freud added the analysis of the transference only a good many years later.

alism typical of his epoch.² True too, one can here and there come across passages in his writings afterwards which reflect the same position. But for the most part, as the years went by, his pondering about mind and body grew more complex, not less. It bothered him, this mind/body conundrum. He considered it important. He refused to settle for easy answers.

He puzzles, for example, over the "mental-physical behavior" of hypnotized subjects (1905b, p. 295). He puzzles over "the concept of instinct", which he decides must lie "on the frontier between the mental and the physical" (1905a, p. 168). He makes this extraordinary statement to what must have been a quite bewildered group of medical students:

Neither speculative philosophy, nor descriptive psychology, nor what is called experimental psychology (which is closely allied to the physiology of the sense-organs), as they are taught in the universities, are in a position to tell you anything serviceable of the relation between body and mind....

(1915, p. 20).

Nothing could be farther from nineteenth century materialism. (Perhaps it should be added Freud was not exactly ignorant of the philosophy which was "taught in the universities" in his day. During his own university years he had attended the seminars of Franz Brentano, the founder of phenomenology and the mentor of Husserl.)

² The early (uncompleted, and in Freud's time unpublished) *Project for a Scientific Hypothesis* (1950) is the most notable example.

In his metapsychology it is as if Freud can't quite find the right place for the body, and knows he can't. The body is marginalized; yet it resists marginalization. Perhaps because of an intuition which the theory could not encompass? I like to think this about the man who at one time worked with his hands on his client's muscles while they talked. Is it possible that something he never entirely learned there he also never entirely forgot?

Groddeck

Georg Groddeck (1913, 1949a, 1949b, 1977) is famous for contributing to psychoanalysis the concept of the "id". Less well known is that he was the first body psychotherapist.

Like Freud, Groddeck had long been accustomed to using massage with patients. Unlike Freud, once he started using psychoanalysis Groddeck did not put massage to one side. Convinced of the effectiveness of both physical and verbal techniques, he developed a treatment mode which brought together the two.

Even for an early psychoanalyst this was an innovative, unorthodox direction. Yet in the context of Groddeck's professional life and setting it had a natural logic.

Before he had ever heard of psychoanalysis, massage had come to stand at the center of Groddeck's work. For around twenty years prior to contacting Freud he had been a medical specialist with a very particular practice. His private sanatorium in Baden-Baden mostly accepted patients with chronic "incurable" conditions. Many were what we would today call psychosomatic

patients³; often when coming to Groddeck they were so near death he was their last resort. His success rate with these patients was high, to the point that he acquired a considerable reputation in medical circles.

His primary treatment activity was a unique form of massage. Hot baths and special diets were also prescribed; these however were Kurort standard fare. What was singular was the massage technique itself. It consisted of what today is usually called "deep-tissue work" -- i.e., like Rolfing (Rolf 1977). Pressing in extremely hard with his hands and fingers Groddeck would try to reach the deeper layers of muscle and connective tissue.⁴ This was clearly a massage methodology having little to do with the more typical nineteenth century "Swedish massage" effleurage (i.e., stroking and kneading) techniques. Groddeck himself learned it from Schweniger, his then-famous teacher in Berlin and whose assistant he later became for a half-dozen years in Baden-Baden (Grossman & Grossman 1965, Le Vaguerèse 1985). One of its goals was to relax chronically tight musculature. A second purpose, upon which Groddeck apparently placed great stress, was to open the patient's constricted breathing (1913, 1949a).

Given this background it is not very surprising what happens next. Freud's publications are being talked about; Groddeck

³Today one sees Groddeck frequently cited along with Franz Alexander as a "father" of psychosomatic medicine. And certainly he is. But Roger Lewin (1974) points out how strenuously Groddeck himself would have objected to this category. In his view every illness, from a fleeting headache to a terminal cancer, was at one and the same time an organic problem and a nonverbal expression of repressed psychological conflicts.

⁴There exist several accounts by patients and observers. The best is from a medical colleague, Hermann Cohn (in Jagersberg 1984). What all the reports agree upon is that Groddeck went deep into the tissue and that for the patient it was impressively painful.

reads several. At first he is critical (Groddeck 1913). Soon he is captivated. He decides psychoanalysis is what has been missing from his treatment approach, and he starts in. Using only what he has picked up from Freud's books themselves he begins working with associations, interpreting dreams, and the rest.⁵ Yet at the same time he continues working -- simultaneously, during the sessions -- with his trusted physical techniques. In his opinion these two approaches are not only compatible; they mutually enhance each other.

So why did Groddeck stay on this road, rather than, like Freud, choosing to drop massage? Obviously first because, up to now, the entirety of Groddeck's treatment methodology had been built around his physical techniques, whereas with Freud massage had always been peripheral. A second reason suggests itself too: that the massage/psychoanalysis combination so neatly fitted Groddeck's philosophic standpoint. Groddeck (e.g., 1913) had already argued in his pre-psychoanalytic writings for a concept of "mind-body unity." If his elaboration of this concept was somewhat obscure, his belief in it was ardent. Verbal psychotherapy thus appeared to him as a natural completion of what he was already up to, rather than a competing activity. Verbal work with associations became simply a second channel to the patient's "it" -- *das Es*, the hidden unifying force, Groddeck thought, behind mind and body.

So he massaged and he psychoanalyzed. "In the treatment I rely upon my head and my hands" (1977, p. 1.). Even in his famous first letter to Freud in 1917 he stakes out his position:

⁵Later Groddeck would learn more directly from Ferenczi, who visited him often and with whom he had a long-standing professional exchange.

"I owe my reputation as a doctor originally to my activities as a physiotherapist, more specifically as a masseur" (1977, p. 32.). And for the next sixteen years until his death (in 1934) he never wavered.⁶ Speaking as late as 1931 he is obviously more convinced than ever that "massage and psychotherapy can be usefully used together" (1949b, p. 53). He even announces now that "the practical experience of the medical masseur gives him a far better foundation for the doctrines of the new psychotherapy than can be obtained through the best theoretical instructions about mind and disease" (1949b, p. 50).

Groddeck's massage work was no secret. Ferenczi, Karen Horney and Frieda Fromm-Reichmann were all occasional visitors to his clinic, and clearly they saw a lot of it. Even Freud wrote to him in 1921 that "if I were 15 years younger no devil could have stopped me from sitting on your neck for a few weeks and watching the kind of skills you are practicing, as I did -- earlier on -- with Bernheim" (Groddeck 1977, p. 60). (Obviously the "skills" here had to be the massage/psychotherapy combination; what else for Freud would be different and new?)

Nevertheless, it is not easy to tease out from Groddeck's books and lectures exactly how he worked on his patients' bodies, and how he fitted this together with his verbal interventions. Inevitably, in his writings, his preference is to amuse, to provoke, and above all to spin out his unusual philosophizing. Cases are mentioned only in passing, and only in service of these other aims. We hear endless examples of the puns of the "it", but next to nothing about the therapeutic exchange itself. All the same it is possible to reconstruct, from a number of scat-

⁶See for example 1949a, p. 244.

tered references, the main lines of the methodology he came to develop.

First, underlying his modifications of technique was a new and highly original concept: that of body defenses. Groddeck identifies three kinds of body defense, the types I have elsewhere in this book (chapter 16) called countermobilization, chronic holding and respiratory deadening. Needless to say, in his earlier years he had already been more than familiar with the physiological ramifications of contracted musculature -- effects on circulation, etc. (Groddeck 1913). But then he encounters psychoanalysis: and now he begins to see muscular and respiratory constriction as an essential instrument of psychological repression, in Freud's sense. Sometimes he speaks of these body defenses as suppressing drive impulses and affects (e.g., 1949b, p. 59). Sometimes he gives examples of their repressing a train of thought (e.g., 1949a, p. 123). At one point he even claims, in the context of a minute, very nice description of countermobilization (temporary muscular tightening in order to reduce awareness of an emerging impulse), that psychological repression could not fully succeed without this auxiliary help from the body defenses (1949a, p. 123).

Equally original (and extremely feasible, one might add) was a new theory about the relation between body defenses and psychosomatic symptoms. The body defense, he proposes (1949b, p. 59f.), is first brought into play as a supplementary aid to psychological repression. For example, a tightening of the muscles around the diaphragm can help ward off "unwanted" sexual feelings. Thus this "warding off" is, so to speak, the primary purpose of the body defense. But with time the muscular holding and/or respiratory deadening, if it is kept in place, is sure to

have many secondary effects: squeezing of the organs, reduction of blood and lymph circulation, diminished movements of the lungs, etc. This creates a general physiological condition which renders the person much more susceptible to psychosomatic developments. An actual psychosomatic illness, should one later emerge, will of course have additional, more specific causes.⁷ But the ground will have been well prepared for it through these secondary effects of the body defense.

Groddeck's patient's were mainly residential. In his writings he also never quite tells us exactly how the psychotherapy fitted into the daily life of clinic. Where there formal therapy hours, designated as such? Or was a therapeutic discourse slipped in here and there, accompanying other interactions throughout the day? My impression is that some of both occurred. Very likely the more extended therapeutic explorations, amounting to what today we would call a session, were simply those which took place while the deep tissue physical work was in progress. Probably these massage/psychotherapy exchanges were undertaken at least once a day.

The tone and general direction of these sessions is somewhat easier to reconstruct. Groddeck managed to create a particular atmosphere. The patient during this intense encounter with his body was encouraged to notice also what came to him mentally. And Groddeck's own presence, in his bearing and attitude, evidently reinforced this injunction to listen to what came from

⁷This level of more specific causality Groddeck usually describes as a symbolic manifestation of repressed impulses (e.g., 1949a). His explanations here tend towards the very baroque. One could however have a more cautious theoretical account of the specific causality and still accept Groddeck's interesting hypothesis about the "preparatory" effects of the body defenses.

within. For example, Count Keyersling (1977), a patient for a period of time, recounts that the core of the treatment was Groddeck's "special kind of massage during which he conducted an analysis". Even though during the sessions Groddeck intervened (verbally) relatively little, Keyersling experienced him as "the most incredible catalyst such as I have never considered possible.....all that needed to be liberated in me came spontaneously to my mind....I found one image after the other pouring into my consciousness..." (quoted in Schacht 1977). These exchanges included both interpretations of Keyersling's dreams, and discussions of his childhood past (c.f. Groddeck 1977, p. 90).

What Groddeck tells us of his own experience and technical orientation during such sessions certainly fits with Keyersling's description. At the beginning, he says, the therapist should pay close attention not just to the patient's words but also to his gestures, movements, style of vocalizing, etc. -- i.e., to what today is often called the "process", the "how", as opposed to the "content", the "what" of the patient's messages. Then, as he precedes to work with patient's body, the therapist can learn still more on this level if he minutely watches his (the patient's) "changing expressions" and his "specific changes in breathing" (1949b, p. 48). At the same time he should expect that the physical work will elicit a series of "mental effects" for the patient (1949b, p. 49). In the short run these effects will amount to an enhanced freedom to associate. In the long run they will bring out a deep re-orientation vis-a-vis the therapy itself.

As day by day he is faced by new problems arising out of his changing sensations in massage, his awakening

desire to learn then becomes so intense, that generally, after a very short time, in the company of his doctor, he is exploring new physical and mental fields which would otherwise only be discovered by the greatest of good luck .

(1949b, p. 49)

No need to underline how innovative all this was. But there is more.

Groddeck was also the first psychoanalyst to take the position that one should work systematically with negative transference. Reich (1949) and Fenichel (1941) are often credited with being the first to advance this point of view, but in fact Groddeck did so many years before them.⁸ One way to go about this was crude but apparently effective: often he would simply out and out ask the patient what he had against himself, Groddeck; and then let the patient track his associations to the intervention (1949a, 1949b). A second, more interesting strategy concerned dreams. Groddeck worked extensively with them, and whenever listening to a dream he would look especially for disguised hints of negative attitudes and feelings towards the person of the therapist (1949a).

Equally innovative were some of the ways he approached his patients' childhood past. Partly, like Freud and the other analysts of this period, he appears to have given strong weight to memories having to do with early sexual and Oedipal conflicts. But in addition he attempted to help his patients understand elements of their preoedipal and preverbal pasts; and considered

⁸As did Ferenczi too, thanks to Groddeck's influence. See below.

this extremely important (1949a). Here too he was far ahead of his time. He held that therapy should illuminate (a) the real events which took place during preverbal infancy; and that this should especially include (b) a reconstruction of former oft-repeated interactional patterns between mother and infant, as well as (c) hypotheses about how the mother's inner ambivalence, envy, sense of loss, etc., may have unconsciously influenced her actions in these exchanges.⁹ Hardly the usual fare in post-World War I analytic writings! But in a sense, not entirely surprising -- given that he was working so extensively with the body. A methodology of the kind Groddeck had developed could be expected to evoke countless traces of the preverbal past.

Ferenczi

Though never a body psychotherapist Sandor Ferenczi came remarkably close. In the process he helped lay the foundation for what would come later.

In part this development was due to Groddeck, who became an enormous influence upon him. Ferenczi began reading Groddeck's writings, at Freud's urging, in 1917. He arranged to meet Groddeck in 1920, after which they became fast friends. The exchange between them, which was both personal and professional, continued until Ferenczi's death in 1933. The gregarious Ferenczi had connections with many, but Groddeck was probably the person

⁹Groddeck even had mother-infant pairs at times in his clinic. In order to treat a somatic condition of an infant he would insist upon seeing them together as well, and upon treating the mother too.

with whom he maintained the strongest allegiance.

Small wonder then that Ferenczi also in his way turned to the body. The exact path by which he arrived there, however, is worth recounting. One can divide Ferenczi's approach to the body in therapy into three distinct phases.

1. In the first phase, roughly 1917-1921, the body appears as a sort of enemy to analysis.¹⁰ This was before Ferenczi had encountered Groddeck. He had already begun to pay more than, for his day, the usual attention to his patients posture, gestures, movements, and vocal intonations. He was convinced some secret lay here. But the idea he came to was that when a patient displayed out-of-the-ordinary postures or movements, he was probably avoiding important thoughts and associations. One could even understand this as a form of displaced masturbation, Ferenczi thought: the body was being used, unconsciously, for a form of discharge. Libido was being channeled away, so to speak, instead of being allowed to bring thoughts and associations into consciousness. ("These apparently harmless activities can easily become a hiding-place for the libido" (1926, p. 193).) Body movement was thus a kind of "short-circuiting" (1926, p. 193).

¹⁰The distinctness of these three phases is easy to establish. The exact dates require some guesswork. Ferenczi was already writing about movement and posture as an evasion of thought-processes in the therapy as early as 1912, in his article "Symptom-Constructions during Analysis" (1950, pp. 193-212). But I am guessing that his first use of his "active technique" as a "solution" to have been around 1917. This was when Ferenczi returned to a normal practice again, having served during the early years of World War I as a military psychiatrist.

The first description of the active technique shows up in his paper "Technical Difficulties in The Analysis of a Case of Hysteria", read at the International Psycho-Analytical Congress in 1918 and published in 1919 (1926, pp. 189-217). The patient is described as having resumed therapy after a long break. Most likely the break was during the disruption of the earlier war years.

It worked to undercut the therapy.

From these reflections was born the beginning version of what Ferenczi called his "active technique". It was "active" only in this highly limited sense: occasionally the therapist might suggest to a patient that, instead of permitting a particular movement or posture, he (the patient) *suppress* it. And that he then see what "material" come subsequently into consciousness. The "activity" involved was thus the suppressing. Almost any unusual posture seems to have been a possible candidate for this intervention, or almost any movement -- "unseemly wriggling, plucking at and stroking the hands or other parts of the body," and the like (1926, p. 207).

Thus in this phase Ferenczi saw himself as eliminating an interference coming from the body. Acts of the body represented an evasion; the therapist should unmask the ruse.

2. The second phase covers, approximately, the years 1921-1926.¹¹ Having already read Groddeck and exchanged letters with him, Ferenczi in 1921 finally begins spending time with Groddeck; and the impact upon him is profound. His, Ferenczi's, new "active technique" is not discarded; but it undergoes a thorough metamorphosis, and Ferenczi's thinking about it is transformed as well. Now the goal becomes no longer to get the body out of the therapeutic process, but to get the body into it.

On the technical level a form of permission now replaces the former prohibition. Ferenczi encourages his patients to become more aware of their on-going body experience; and when they feel

¹¹The last time Ferenczi describes the active technique as one of eliminating interference coming from the body is in "Further development of an active therapy in psycho-analysis", a paper delivered at the IPA congress in 1920 (Ferenczi 1926, pp. 198-217).

their bodies wanting to move, or to take on an unaccustomed position, to allow this to take place. This amounts to an almost complete theoretical reversal, in other words. Acts of the body are now seen as a potential means of revealing what is hidden, rather than as a form of evasion. One could say that, under the influence of Groddeck, Ferenczi for the first time begins to trust the body.

Even when on occasion he continues to use the old version of the "active technique", proposing that a client block a movement or a postural impulse, Ferenczi now sees the purpose of the intervention completely differently: as an alternative way to let something new emerge via the body. By holding back one such mode of letting the body express itself, the patient may make room for some second, more interesting mode (1955, p. 115).

He develops in this period another innovation as well, and one equally important: the concept of systematic work with negative transference. This too came from Groddeck, as he acknowledges (1926, p. 225). He sees such exploration as both an end in itself, and as a necessary prelude to satisfactory work with body movements and postures. The patient will be reluctant to open up by means of the body, Ferenczi reasons, if the right degree of confidence in the therapy is lacking. Examination of the negative transference will help create the conditions for that confidence.

3. The third phase (1926-1933) is especially fascinating.¹²

¹²In picking 1926 as the beginning of this phase I reason as follows. (a) The wonderful detailed descriptions of work with regressive states, which I consider a hallmark of the third phase, become a regular feature in his writings only starting with "The principle of relaxation and neocatharsis" (1955, pp. 108-125), first delivered as a paper at a congress in 1929. (b) Prior to that 1929 paper, the last major review of his "active technique" is in "Contra-indications to the

Here Ferenczi successfully deepens what he is doing, and at the same time arrives at an impasse.

What is most striking in the texts from this period is a new clarity about how to work with trauma. The interventions with the body are now bringing not just important information and "material", but also prolonged, intense body regressive states -- "a kind of re-experiencing" (1988, p. 54). This is a major shift in his technique. No wonder that his letters to Groddeck (Ferenczi/Groddeck 1986) now begin to reflect a new excitement about his work. He has become adept at helping his patients not just to touch upon former painful experiences, but also to remain in contact with a present regressive state, letting it consolidate itself. Whereas before he used to cut off these states once they appeared, by interpreting them or by flooding the patient with questions, he now understands how to support the patient's staying there (1988, p.30f.). He has a new sense of how a regressive state can unfold.

As a result he learns much. Among other things, about sexual abuse. Ferenczi tended to treat much more severely disturbed clients than most analysts; this was considered his specialty. Not surprisingly, from the point of view of what we know today, once he became truly skilled at aiding these patients to use the body to make more contact with their past, stories of abuse, and all the emotional pain with it, began to show up right

'active' psycho-analytic technique" (1926, pp. 217-230), read at a congress in 1925. This is an important and rich statement, but, as with his other writings in this period, it says next to nothing about body regressive states. (c) Between 1925 and 1929 there are no more detailed overviews of the "active technique". I think we can therefore assume that it is only around 1926, or perhaps a year or two later, that he reaches the level of technical skillfulness which in this chapter I correlate with his third phase of dealing with the body.

and left. This forced him to re-evaluate the view, then dominant in analytic circles, that when patients hinted at such events they were largely responding only to their own fantasies. The evidence he was encountering by intervening through the body was too compelling. "Having given due consideration to fantasy as a pathogenic factor," he writes,

I have of late been forced more and more to deal with the pathogenic trauma itself. It became evident that this is far more rarely the result of a constitutional hypersensibility in children (causing them to react neurotically even to a commonplace and unavoidable painful experience) than of really improper, unintelligent, capricious, tactless, or actually cruel treatment.

(1955, p. 120)

Especially in the area of incest and sexual abuse, he adds, too many "parents and other adults do indeed go to monstrous lengths" (1955, p.121).

In a similar vein he changes his ideas about the preverbal past. He decides it is mostly real events from the preverbal era -- genuine deficiencies in the objective interactions between infant and parents -- which are responsible, along with subsequent traumas, for the later adult symptomology. Here too he has learned from Groddeck, of course. By intervening with the body, moreover, he feels he can now at times bring the patient "back to phases of development in which, since the organ of thought was not yet completely developed, physical memories alone were registered" (1955 , p. 122). Back, in other words, to the preverbal

past. The patient's exploration of his body brings up "physical memory symbols" -- i.e., motor memories (1955, p. 119).

Not only do these "physical memory symbols" supply much-needed information for the therapy; they are also invaluablely convincing to the client. Summarizing such experiences from a number of cases, he reports:

this time the reconstructed past had much more a feeling of reality and concreteness about it than heretofore, it approximated much more closely to an actual recollection, whereas till then the patients had spoken only of possibilities or, at most, of varying degrees of probability and had yearned in vain for memories.

(1955, p. 119, italics in original)

Some aspects of early childhood can only be reached in this way, he thinks. *"The 'memory' remains fixed in the body and only there can it be awakened"* (1955, p. 262, italics in original). He even takes the position that no analysis is really complete without its having reached this "deep infantile stratum" (1955, p. 141).

These experiences with his patients now lead him also to develop a concept of splitting as a defense against traumatic pain.

It seems likely that a *psychotic splitting off* of a part of the personality occurs under the influence of shock. The dissociated part, however, lives on hidden, ceaselessly endeavoring to make itself felt, without

finding any outlet except in neurotic symptoms.¹³

(1955, p. 21)

His *Clinical Diary* shows how central this notion became in his practical work during this period. He uses it extensively, almost constantly.¹⁴ Intervening by means of the body now becomes a way to recover these "disassociated parts".

Paradoxically, however, it was precisely because of this leap in technical progress that Ferenczi came to an impasse. As he himself became all too aware. Given his technical creativity, he most likely would have gotten beyond it, had he lived longer; but as of his death in 1933 the contradiction remained unresolved.

The essential difficulty he arrived at was this. He began to see (e.g., 1988, p. 108, p. 169, p. 193) that it is not enough for a patient just to "return", through regressive work, to former conflicts, hurt and rage, affective paralysis, etc. A client might go over and over to this early pain. And these experiences in the therapy might seem profound, to both client and therapist. Yet, when nothing beyond this takes place, after a while these states take on a quality of seeming stuck, repetitive. Their evident curative potential is not being fully real-

¹³Note that this idea is only superficially similar to Freud's earlier concept of splitting (in the latter's short paper on fetishism): it is not (or not only) a disavowed perception, but an entire "part of the personality" which is split off. And which "lives on hidden, ceaselessly endeavoring to make itself felt."

¹⁴ Melanie Klein (e.g., 1975) would of course eventually develop the concept of split-off self-parts quite a bit further. Regretfully Ferenczi is too seldom recognized as the source of this important idea. Klein, who had earlier been Ferenczi's patient and who periodically had continued contact with him, certainly must have been familiar with Ferenczi's discussions of splitting.

ized. Something more, some basic further step, must be necessary.

What further step? I think an answer can be given today. In two previous chapters of this book I have discussed the technical complexity of work with body regressive states. I suggested that the "going back" to motor representations of the past is only a beginning. The more important side is an unfolding of latent body resources (affectmotor schemas) which earlier were not experienced as developed and available. Reading Ferenczi's extraordinary accounts of his trials and errors, his reflections and his hesitations regarding body regression, I have no doubt this is exactly the key he unsuccessfully sought.

Instead he tried to push himself -- and agonizingly so, as the *Clinical Diary* makes clear -- down another path. He became convinced that the source of healing must become the therapist himself. This should be the further step. The therapist must attain a kind of heroic purity, a nonconflictual radiating parental benevolence. Then, when in a regressive state, the patient could not only encounter past pain but also warm himself in the rays of this sun.

A grandiose, an impossible ideal; and it led directly to an equally misguided project: the experiment of "mutual analysis" (1955, 1992). Here Ferenczi's idea became that the therapist should once in a while, during sessions, explore his own past, with the patient on his side helpfully posing the right analytic questions. The goal here was that they would regress a bit together, so to speak. And that by opening himself in this fashion the therapist would finally reach his own best vein of good-parent givingness.

But "mutual analysis" proved a dead end, as even Ferenczi

himself came to see. Rather than relieve his countertransference difficulties it only intensified them. The *Clinical Diary* makes this abundantly clear.¹⁵ Trying to be the one who must fill in all the empty places a patient encounters, Ferenczi felt himself drained, exhausted, hateful. His professional borders eroded; he found himself seeing certain clients hours at a time, and putting up with endless demands being made on him outside the therapy hours.¹⁶ He came to the same cul-de-sac Winnicott would discover two decades later.

I have elsewhere stressed to what extent work with regressive states must also rest upon an adequate grasp of countertransference reactions.¹⁷ Especially critical is an understanding of how elements from the client's past can become reflected in the

¹⁵Some of his letters to Groddeck (e.g., Ferenczi/Groddeck 1986, p. 83) allude to this too.

¹⁶He went over his clients' borders too. Caressing body contact and "kisses" became part of his mode of support, leading to much condemnation on the part of Freud.

I strongly suspect this issue has been greatly misinterpreted, both by Ferenczi's contemporaries and later commentators. The *Clinical Diary* makes evident how Ferenczi was trying by every means possible to re-create an ideal atmosphere of "good parenting" nourishment. Likely the infamous "kisses" were simply a peck on the cheek, the "caresses" a light stroking of the client's head, and the like.

This is the most reasonable reconstruction, for these reasons. (1) In Hungarian culture (Ferenczi was Hungarian and practiced in Budapest) these are normal forms of parental contact with children. (2) Ferenczi in this period was more tuned in than any therapist of his era to the extreme pain caused in patients by their histories of sexual abuse. One sees over and over in the *Clinical Diary* how seriously he took their desperation. Since his attempts at re-creating positive parental support were designed expressly to counterbalance those frightful experiences, it is hard to picture him playing games with his patients' boundaries in any explicitly sexual sense. (3) The *Clinical Diary*, written for himself alone, is a document of great frankness. Had Ferenczi been toying with sexual closeness, or troubled by sexual feelings, these themes would surely have appeared here. But they do not.

¹⁷See Downing, *Hidden Currents: Working with Transference and Countertransference*, forthcoming.

therapist's countertransference. Given that, in Ferenczi's day, there existed no such theoretical framework for approaching countertransference¹⁸, it is amazing he was able to go as far as he did with the unfolding of regressive states. And hardly surprising he reached a point of stalemate. Even today, moreover, one can still learn much from his observations. The *Clinical Diary* remains some of the most probing writing on regression in the history of psychotherapy.

Had he lived longer, the inventive Ferenczi might well have surmounted these barriers.¹⁹ In that case the odds are high he would have ended up with a methodology rather close to some contemporary forms of body psychotherapy. In a tentative, beginning, exploratory sense, he was already almost there.²⁰

¹⁸In the *Clinical Diary* Ferenczi does speak about his countertransference, and with an admirable self-confronting honesty. One is reminded of some of the writings of Harold Searles (1965, 1979). But he lacked the crucial notion of induced countertransference.

¹⁹Of particular interest in this regard is an innovation he seems to have first explored only during the last year of his life. He began working with dreams in a new way, combining his internal body techniques with what today we would call a phenomenological exploration of the dream (i.e., helping the client bodily to sink more into the sensory surface of the dream, rather than moving at once to interpretations).

Both a letter to Groddeck (Ferenczi/Groddeck 1986, p. 85) in March 1932 and a diary entry (Ferenczi 1988, p. 67) made some days later reflect his enthusiasm about this avenue. Since dreams so often symbolize the body's potential for change as well as the motor traces of trauma, this might well have become the pathway Ferenczi needed to a fuller understanding of how to work with regressive states.

²⁰Why not then, without reserve, just call Ferenczi a body psychotherapist? Richard Meyer (1992, pp. 7-20) in an intelligent discussion does so. I would not, however, for two reasons. First, because, in dealing with the body, Ferenczi used only what I have elsewhere (chapter 7) called internal body techniques, and never external ones. Second, because even in his last years he saw his "active technique" only as a special instrument for severely disturbed patients, not as a general methodology. Of course any choice about the use of such labels tends to be arbitrary.

*The first continuous current:
the Berlin body awareness movement*

Now our story comes to a forking. What will develop into two quite separate lines of influence can be traced.

First some necessary background. During the Weimar Republic in Germany there took place a rather extensive development of the "pure body" disciplines (non-psychotherapeutic work with body awareness, breathing, movement, relaxation, etc.).²¹ This wave was especially concentrated in Berlin. A number of, one surmises, quite gifted explorers/teachers, their names today largely forgotten, contributed to a movement not unlike the so-called "human potential movement" of the 60's and 70's in the U.S..

Two of the more important figures in this movement were Elsa Gindler and Rudolf Laban. Gindler (1984) had begun as a gymnastics teacher. By the time of the early 1920's she had evolved into something quite different. Her classes emphasized the bringing to awareness of highly differentiated body sensations. Slow and subtle experiments with movement and posture were the usual vehicle for this learning of body *Konzentration* (Gindler 1984). Laban (1926, 1963, c.f. Friedmann 1989, Foster 1977), coming from a background of professional dance, focused upon movement in a more expressive sense. His many exercises and

²¹Some of the roots of this German movement can even be traced to the late nineteenth century. Some experimental new ways to teach gymnastics, movement for actors, singing, and the like became sources for a different approach to the body. Gradually the body practices embedded in these teachings evolved into a group of disciplines in their own right. Kallmeyer (1970) has a particularly interesting account of this historical background. See also Friedmann 1989, Gindler 1984, D. Johnson 1994 and Speads 1986.

group movement orchestrations were designed to liberate what he saw as "natural" movement, which he felt mostly was tightly buried under an unconscious overlay of cultural restrictions and inhibitions.

Gindler and Laban had many followers, as did other teachers who were working in a more or less similar vein. It became a highly self-conscious movement, generating its own publications, congresses, and even at one point a professional organization (Friedmann 1989). It spread well beyond Berlin also. Students of Gindler, for example, began regularly teaching her work in other parts of Germany. Laban himself set up centers for the study of his approach in a half dozen German cities. Eventually followers of Gindler, Laban and others would bring their work to additional countries as well. (Charlotte Selver (Selver & Brooks 1980) for many years carried on the Gindler tradition in the U.S., for example.)

Given the extent of this "body awareness" movement it seems almost inevitable that its practices would here and there be integrated into a psychotherapy approach. And this is exactly what happened. It was a cross-fertilization which had some lasting results, moreover. The Berlin body awareness movement generated some new forms of body psychotherapy which, while undergoing inevitable changes and transformations, have endured right up to our own day. Both Groddeck and Ferenczi, in contrast, exerted only an indirect influence upon what came after them. Now, however, with these off-shoots of the Berlin body awareness movement, for the first time we see the emergence of styles of body psychotherapy which will be handed on from one practitioner to another. A tradition of teaching and supervision is begun.

A good example is that of the Heyers, a couple in Munich. Starting around 1925, the two of them, he a psychiatrist and she extensively trained in massage as well as in Gindler's body awareness discipline, began experimenting with working as a team with psychotherapy patients (G. Heyer 1935, c.f. Stolze 1984c). Typically they would see the same patient in separate, parallel sessions. For the most part the verbal therapy (a potpourri of Freud, Jung, and a lot of hypnosis techniques) was predominantly carried out by the one, and the parallel body work (in separate sessions) by the other; but not entirely, as each gradually implemented elements of the "specialty" of the other (G. Heyer 1935, p. 108.). He turned into somewhat of a body-oriented psychotherapist, and she somewhat of a psychotherapy-oriented body worker, if you will.

Judging from their writings they appear to have given little attention to the possible transference complications which might be evoked by such a team approach. Apart from that, however, their theoretical framework for their verbal/body combination was, for the early thirties, a surprisingly sophisticated one. They approached all patients, bar none, as having a "double-sidedness" (*eine Doppelseitigkeit*) to their problems -- a mental and a body side. ("Every mental disturbance has its somatic equivalent". *Jede seelische Störung hat ihr somatisches Äquivalent* (L. Heyer 1935).) Particularly interesting, technically speaking, is their emphasis upon physical work with breathing; here clearly they went farther than Groddeck. Massage techniques were also used extensively.

Another example is Gertrud Heller (Heller 1984). Also trained in Gindler's approach, she left Germany just before World War II and took a position working with psychiatric patients at

Crichton Royal Hospital, in Scotland (Becker 1981, Heller 1984). There for more than a decade she developed ways to use Gindler's focus upon body awareness as a basis for intervening in a psychotherapy context. Eventually she taught what she had been doing to others, especially on trips back to Germany. One rather important contemporary form of body psychotherapy, Concentrative Movement Therapy (*Konzentrativen Bewegungstherapie*), widely practiced in psychiatric settings in Germany today, can trace the lines of its teaching directly back to the Heyers and to Gertrud Heller (Gräff 1983, Meyer 1984, Stolze 1984b, Stolze 1984c).

Magda Proskauer (Proskauer 1968), my own first body psychotherapy teacher, is another example. As a young woman in Berlin she was extensively involved in the body awareness movement.²² Later she emigrated to California, where she combined delicate techniques for re-organizing a patient's breathing with a Jungian verbal psychotherapy approach. Since Proskauer eventually became well known on the U.S. west coast, many other psychotherapists in turn were exposed to her work.

A high point, historically speaking, of the body awareness movement/psychotherapy overlap seems to have been a congress on psychotherapy in Dresden in 1931. In addition to the usual gathering of therapists, a number of practitioners of the body disciplines apparently were present (Meyer 1984, Stolze 1984c). The Heyers were also there, and presented a report about their work (Stolze 1984c). Groddeck came too, and read one of his finest papers, "Massage and Psychotherapy" (Groddeck 1977, pp. 235-240). There appears to have been many fruitful exchanges about how physical and body awareness techniques, on the one

²²Particularly with Heinrich Jacoby, an important colleague for many years of Elsa Gindler.

hand, and psychotherapy, on the other, might best be intertwined.²³

The second continuous current: Reich and the followers of Reich

Wilhelm Reich (1949) began first experimenting with the body only around 1932. And he began actually practicing something which could be called body psychotherapy only around 1935. In a sense therefore he came rather late to this field.

Yet from another point of view he was its most influential early figure. This is because he not only built up a special methodology, but also developed an elaborate and encompassing theoretical framework. Both the practice and the theory he taught to a good many others, moreover. What eventually became known as Reichian therapy deserves therefore to be identified as a separate historical current.

What were its roots? Psychoanalysis, of course, Reich during his early professional years being part of the "second generation" of Vienna psychoanalysts around Freud. But what helped to create his interest in the body?

One major influence in this regard must have been Paul Schilder. Today Schilder is known for having almost single-handedly created an entire sub-domain of psychological research.

²³With respect to the Berlin body awareness movement, mention might be made also of Heinrich Schultz, the inventor of a famous set of relaxation techniques called Autogenic Training (Schutz 1932). Schultz was also based in Berlin, where he practiced and taught his method from 1908 to 1969. His original training had been in hypnosis. Over the years Autogenic Training has often been incorporated by psychotherapists into their work with clients, a borrowing of which Schultz himself was fully supportive (Schutz 1932, pp. 360ff.).

His seminal work, *The Image and Appearance of the Human Body* (Schilder 1950), stimulated what now is a minor discipline in itself, the study of "body image."

Less well appreciated is how very early Schilder's impact was being felt. The first version of *The Image and Appearance of the Human Body* was published in German in 1923.²⁴ Schilder at this time was also Reich's supervisor. Reich was doing his psychiatric residency at the Vienna Neurological and Psychiatric University Clinic, where Schilder was one of the directors (Raknes 1970). It was a period in which Schilder was brimming over with ideas about how psychiatric patients experienced their bodies; about how they moved and held their bodies; and even about how early interactions with their parents may have shaped postural and motor tendencies.²⁵ For Reich this had to have been an important first push towards connecting the physical and the psychological.²⁶

²⁴A chief difference between this earlier version, called *Das Körperschema*, and the later version in English is that in the 1923 edition the psychoanalytic point of view is mentioned, and approvingly; but it is not explored in detail until the 1935 (the first English) edition. A second difference is a much wider ranging set of phenomenological descriptions in the English edition.

²⁵ Though rigorous theory was not his forte, in whatever direction Schilder moved he seemed to leave fruitful insights in his wake. I have already mentioned (chapter 23) his early discovery of induced countertransference. It is extraordinary as well to see published in 1928, in a paper on early childhood development, a hypothetical discussion of how parental responses might have a formative influence upon an infant's emerging postural explorations and motor expressions (Schilder 1964). A anticipation of one of the major insights of contemporary infant development research.

²⁶For example, in a paper written at this time, about a case he treated under Schilder's supervision, we find Reich already using Kretchmer's (1925) body types to describe the physical structure of the patient. Schilder in this period was enthusiastic about Kretchmer (e.g., Schilder 1953). Much later Reich would turn more extensively to Kretchmer's body types, in attempting to develop a diagnostic means of "read-

A second influence was Ferenczi, the most important of Reich's mentors from within the Freudian circle. As Reich's biographers have pointed out, the two men were not only close; Ferenczi was also the only of the senior psychoanalysts to remain supportive of Reich right up to the latter's dismissal from the International Psychoanalytic Association (I. Reich 1969, Sharaf 1983). Even in his earliest published papers in the mid-twenties, all on psychoanalysis proper, Reich (1975) cites Ferenczi far more than any other analyst, apart Freud himself.

Obviously Reich must have heard in detail about Ferenczi's experiments with body interventions, since Ferenczi's long gradual movement in the body direction corresponded almost exactly to the years of their friendship. From Ferenczi he must have heard plenty about Groddeck, and about Ferenczi's pilgrimages to the latter's clinic, as well. There seems to be no evidence Reich himself ever met Groddeck. And he does not mention Groddeck frequently in his writings. Significantly, however, when Reich does speak of Groddeck he does so (e.g., 1980, p. 14) in a quite singular manner: as being one of the only two analysts -- the other being Ferenczi -- who prior to Reich had understood the importance of the role of the body in therapy.²⁷

A third influence is especially interesting. Reich moved to Berlin in 1930 and lived there until 1933. He began a friendship with a woman named Elsa Lindenberg, and they ended up living as a couple for the next six years. Lindenberg was a student and colleague of Laban at this time. Laban since 1930 had been

ing" body structure.

²⁷Reich also criticized them both for "psychologizing the physiological". Reich thought that his own model, being based upon a concept of primordial "energy," was a preferable alternative. C.f. my discussion of this issue in the next chapter.

director of dance at the Berlin Staatsoper; Lindenberg had come into the troupe as a dancer (Friedmann 1989, Sharaf 1983). Later, after leaving Germany with Reich, she would teach a version of Laban's approach in Denmark and Norway. Through her person Reich thus had direct contact with the Berlin body awareness movement.²⁸

It seems hardly an accident that it was soon after having begun the liaison with Lindenberg that Reich first undertook to intervene with his patients on a body level. Even more confirming of this Laban/Lindenberg influence is the form that these early experiments took. In part, Reich consciously modeled what he was doing upon Ferenczi's active technique (Reich 1942, p. 147; 1949, p. 343). But from the start the goal was different. Ferenczi saw body interventions chiefly as a means of reaching otherwise inaccessible segments of the past. Reich consistently shows, in his discussions of cases from this period and afterwards, almost no interest in "motor memories", almost no interest in using the body to make the past conscious, or the like. Instead he sees the purpose of body interventions as bringing expressive movement alive. What is special about body interventions becomes their ability to release spontaneity, vitality, the natural man hidden beneath the patient's constricting defenses. This is patently the universe of Laban, not of Ferenczi. Reich took Laban's emphasis upon the uncovering of natural expressive movement; transposed it to a psychotherapy setting; and then over

²⁸Reich was three years in Berlin during the height of this "body discipline" wave. David Boadella (personal communication, 1993), who has extensively interviewed Elsa Lindenberg about Reich, reports she told him Reich was extremely interested in her own studies with Laban, Elsa Gindler, and the like. He would once in a while himself attend a lesson or a class.

the years modified how he used physical techniques to attain this goal. In the beginning (years 1932 to 1935) he just relied upon his own version of the "active technique", letting a client now and then explore what seemed to want to emerge in his or her body. Later, around 1935, he added work with massage and breathing (Boadella 1973, Sharaf 1983). But the overall Labanian ideal of reaching natural expressive movement remained a primary purpose.

During his years in Oslo (1934-1939) Reich began teaching this approach to other therapists. In 1939 he moved to the U.S. east coast, where, until his death in 1957, he continued to develop, teach, and write about his new methodology.

The result was a theoretical model with a strong inner coherence, much attention to clinical detail, and a distinct supporting *Weltanschauung*. It is a model which still shapes the practice and the thinking of a good many body psychotherapists today.

For my own part, I must add, it is a model with many dubious aspects. I find Groddeck, Ferenczi, and the Berlin body awareness movement to be sources of richer inspiration, despite the more fragmentary nature of their theoretical reflections. However, Reich's model is historically so important that it merits a more extensive discussion. I will give explicit reasons for my reservations in the next chapter.

Chapter 26

REICH'S DUBIOUS HERITAGE

I am both pro and contra Reich. All in all, more pro than contra. What I want to speak about here however is the area of divergence. Reich's method was based on certain premises with which I profoundly disagree.

First, more briefly, what I find valuable in Reich.

While still a young psychoanalyst in Freud's circle Reich systematized a careful technical approach to working with resistance (Reich 1949). No one had done that before.¹ Until then analysts had been interpreting whatever the patient brought up, in the order in which he brought it up. Reich proposed instead that "surface" interpretations (less threatening elucidations) should come earlier in the therapy, and "depth" interpretations only later. Today this idea is commonplace in analytic theory.

¹Except for Groddeck, who was the first to emphasize systematic work with negative transference from the beginning. Groddeck however never came to Reich's major insight, that "surface" should be interpreted before "depth" (see shortly below).

It began with Reich.²

During the same period he also extended the concept of character far beyond what Abraham (1927) and Freud had done with it. He distinguished more exactly between symptoms and "character" (today the term 'personality', which has the same meaning, is more often used); and held that it is ultimately the patient's character, rather than just his symptoms, which should be the target of the therapist's interventions (Reich 1949). Another commonplace today. These several ideas alone changed the nature of psychoanalysis.

Following his classical psychoanalysis period, Reich developed in the early 1930's a new style which he called "character analysis". He was still working only verbally. And to a certain degree still analytically. But a new distinction now dominated his work: between the 'what' the patient said as opposed to the 'how' with which he said it. Often Reich focused for the greater part of a session upon this "how" -- upon voice tone, posture, facial expression, and the like (Reich 1949). Fritz Perls (1969) would later place that productive idea at the heart of his own Gestalt therapy. (No accident. Perls was a patient of Reich's during the character analysis period.)

Finally there was the move to the body. Groddeck and others had already used body techniques with psychotherapy patients. But Groddeck left no legacy; he seems to have taught his approach to no one. Reich, on the contrary, transmitted his repertoire of

²Other aspects of Reich's technical approach to resistance and to negative transference today look rather primitive. His style was bullying and authoritarian, and he had little feeling for the hidden threads of positive transference which lie intertwined with those of negative transference (c.f. chapter 21). He also posed none of the searching questions about countertransference which his mentor Ferenczi pursued so intensely (c.f. chapter 26).

techniques to many others. He was the first as well to write in any detail about their role in therapy (Reich 1949).

These are enduring, substantial, contributions. Endlessly innovative, Reich was one of the great pioneers.

Now the contra.

When he moved to the body Reich not only created new techniques. He also elaborated a new theory. We might call this for short the "energy model." This model has been influential; in one form or another it has been adopted by many contemporary forms of body psychotherapy. I am opposed to this model, however. I think it has hindered rather than helped the evolution of body psychotherapy.

Before going into any criticisms I will try to summarize Reich's theory. At its core stand four components.³

The "energy existence" hypothesis. There exists, thought Reich, a special energy which suffuses the body. An energy which official science has refused to recognize. Analogous to electricity -- but not the same as electricity -- , this energy circulates throughout the body. It moves at specific velocities and follows specific routes. Reich at different times gave different names to this circulating force. Among them were "orgone energy," "bio-energy" and "vegetative energy".

The "health = flow" hypothesis. Good health, Reich claimed, is at bottom dependent upon one thing alone: an unimpeded flowing of this energy. That includes physical health and psychological

³The model I am briefly describing here is discussed by Reich in many of his works. The later essays in *Character Analysis* (Reich 1949) are representative. Good overviews of Reich's model can be found in Boadella (1973) and Sharaf (1983).

health alike. What prevents the energy from flowing properly, however, is that our muscles tighten up. Chronic tensions are created, muscular "blocks" which together form a defensive "armor".

These blocks, he thought, largely develop because of psychological reasons -- e.g., something repeatedly scares us, we repeatedly tense certain muscle groups, eventually this tightening coalesces into a block. This forming of the armour mainly occurs during childhood. The primary aim of therapy must be to diminish or remove the blocks, allowing dammed-up energy again to flow freely.

The "wider scientific" hypothesis. A number of other natural phenomena, ones lying quite outside the domain of psychotherapy, can also be explained by the functioning of this energy, claimed Reich. These include qualities of blue light seen at the horizon at dusk, temperature changes in a container made of wood lined with iron, some brown flakes found after thawing a frozen solution of earth and water, and the like. On this level of discourse Reich thought he had found a scientific key which the coming generations would use to unlock secret after secret.

The "ontological" hypothesis. This energy not only permeates the human body, thought Reich; and not only shows up as the cause of some miscellaneous other natural phenomena. It also has an ontological status unlike that of anything else.

Briefly, this energy underlies --i.e., is a kind of ontological cause of -- both material objects as we experience them externally and our own mental life as we experience it internally. To recognize this is to solve philosophy's mind-body problem: both mind and body have a common origin, the doings of this energy. To recognize this also is to understand the nature of

religion: whoever postulates a "god" has had a vague intuition into the existence of this same energy, which, as ultimate responsible cause, is omnipresent throughout the universe.

In stating where for me the energy model falls short I am going to focus on only two of the above four claims, the "energy existence" and the "health = flow" hypotheses.

About the other two I will mention only the reservations which lead me to put them here to one side.

The "wider scientific" hypothesis I find, frankly, an embarrassment. This is the side of Reich which led him to construct a series of arcane devices -- the "orgone box" (sit in it and it gets the stuck energy in you moving again), the "cloudbuster" (point it at clouds and you can make rain come), etc.⁴ Those who take these "discoveries" seriously today are few in number.⁵ That of course is no argument against these claims. I am merely acknowledging that what I find of interest in Reich lies elsewhere.

The "ontological hypothesis" is no doubt less bizarre. But is it any more intellectually palatable? How can an "energy" at one and the same time (a) have a spatial presence and location, flowing along certain paths at certain speeds, yet (b) be the ontological agent causally responsible for everything everywhere?

⁴One should add, however, that Reich never saw the orgone box, or "accumulator", as something which could substitute for therapy.

⁵ For the most intelligent defense I know of with respect to Reich's claims in these areas see Boadella (1973). Boadella argues that many of us who dismiss this side of Reich are perhaps judging by too strict criteria. In other words, if, as he thought, Reich had truly uncovered a new scientific domain, then it would be to be expected that many of his more specific hypotheses would be only half right. This is typical of the earliest formulations of a new paradigm.

This seems an obvious confusion of levels of discourse. The "ontological hypothesis" seems to me to contain little more than warmed-over nineteenth century German *Naturphilosophie*. You either like that sort of thing or you don't.

What I am therefore going to discuss is kind of pruned-down version of the energy model. Leaving aside what may or may not apply to the cosmos in general we come back to the human body itself. Does there exist a special energy which circulates through it? And is this energy the key to psychological health?

Note to begin with that these are separate questions. I would like to emphasize that.

Arguments for or against the energy model often revolve around the first question, the "energy existence" hypothesis, alone. The implicit assumption is that *if* such an energy should be found *then*, no quarrel, its role as the foundation of our psychological health could be taken for granted.

Frankly I don't think that follows at all. In fact what I find most deserves critical scrutiny is this "if...then" assumption.

Here is why. First, I think the "energy existence" hypothesis as a hypothesis is an entirely reasonable one.

I don't believe for a moment it has been "proven." Many claims have been made to that effect -- citing, e.g., experiments with acupuncture, or with Kirilian photography (to take just a couple of examples). And indeed some of these claims are rather interesting. But I have yet to come across any which seemed to show unassailable evidence of (a) a unique, special energy (not electricity, not magnetism, etc.) which (b) does (more or less) the things Reich claimed it did.

Yet so what? Does that mean the "energy existence" hypothesis has been shown to be false? Hardly. Does it mean it is unintelligible? Not at all. It is in principle a testable hypothesis, and some form of it -- perhaps in conjunction with some different paradigm not yet even thought of -- may indeed someday be shown to be true. There might well exist a body energy which has not yet been demonstrated; there even might exist two or three or still more of them. After all, why not? Surely scientific discovery has not yet emptied its bag of surprises?

My own position towards the "energy existence" hypothesis is thus one of sympathetic agnosticism. Some version of it might someday prove true. What then about the next step in Reich's reasoning? What about the "health = flow" hypothesis?

Here is where my skepticism increases. Suppose one day it were in fact proved -- impeccably, to the satisfaction of anyone and everyone -- that there exists a "new" energy X in the body (or two or more such energies, etc). Why ever should we then expect that this energy X would turn out to be the secret key underlying psychological health? What findings, those of marginal science included, give the least indication that such an idea might be true?

The fact is that everything we already know about the biochemical underpinnings of psychological states points in the opposite direction. Enormous advances have been made in the last decade -- thanks to which, for example, we can now prescribe medication for a variety of severe psychiatric symptomologies,

from bipolar disorder to psychosis.⁶ But look at the overall picture which is clearly emerging: the more we discover, the more stunningly complex the biochemical substratum appears. Discrete biochemical elements are more and more being identified with discrete separate effects. The idea of a single bodily cause for (or a single bodily correlation with) our psychological states looks now more improbable than ever.

One might of course object to my making that comparison. One might object that this special energy would be of a different "order" than the biochemical phenomena which are being uncovered by current research. Well, fine. Assume it is of a different order. How does that help in the least? This is only to define it by a negative characteristic, nothing more. A negative characteristic doesn't in any way increase the probability that, different order or not, this energy would turn out to be the magical keystone of the mental health arch.

My own expectation, on the contrary, would therefore be a considerably more modest one. Suppose, again, that one day the existence of another bodily energy should be proved. In that case a reasonable guess is that this energy would, in its changes and permutations, turn out to have only a limited effect upon our mental states. Some effect surely; but nothing approaching the totalistic determining power which has been prematurely claimed for it. In our overall picture of the physiological substratum underlying our psychological condition it would take its place alongside a large and ever growing list of other factors.

⁶Just in case there is any doubt, I am not proposing medication as a substitute for psychotherapy. I see it as, in certain cases, a helpful adjunct to the latter.

So far I have stated a series of general reservations and doubts. I want now to pass to my more serious objections. Let us approach the matter from a different angle entirely. Suppose we bracket the question of whether such an energy exists. Bracket too the question of whether its existence could ever be proven. What about using the energy model "as a kind of metaphor"? (I here repeat a phrase I often hear.) What about simply adopting it on an "as if" basis as a guide for doing therapy? How good a guide is it?

I find it a poor guide, even on that basis. Very poor. For the martial arts, for yoga, for certain meditative disciplines it is perhaps an excellent organizing metaphor. But for the conduct of psychotherapy it is more confusing than helpful. It creates a distorted image both of the nature of human existence and of the way in which therapy heals. Here are my reasons.

1. *It is a relentlessly mechanical model.* This there is no avoiding. The energy flows or it doesn't flow or it half flows...blocks are either present, causing trouble, or they are not present...what we have to do with is rather like the plumbing in a house. When things don't work right something is stuck in the pipes.

Note too the implied image of therapy. The therapist is like the plumber. If you have something stuck you call in this specialist and have him unblock the pipes. Where however in that picture is there any room for human agency? Where in particular is the agency of the patient?⁷

Ironically, Reich often inveighed against "mechanism" as a

⁷C.f. Kovel (1988): "Whatever Reich's genius, his failing was to desubjectify the person."

Weltanschauung. He then turned around and fabricated what is arguably one of the most mechanistic theories in all of psychotherapy.

One strength of psychoanalytic object relations theory is that it has managed, with conscious effort, to develop alternatives to some of the more mechanistic aspects of Freud's original drive theory. Fairbairn (1951), Guntrip (1982), Shafer (1968, 1976), Mitchell (1988) and others have participated in a long and fruitful debate about this problem. It seems to me that body psychotherapy has here an even longer road to travel. First, because there has been little such debate so far. Second, because Reich's energy model is far more mechanistic to begin with than the Freudian libido theory ever was.

2. *It is a reductive model.* In text after text (one could present many examples) Reich starts out by affirming that the "mind" side of ourselves is just as important as the "body" side, and that neither should be understood as the mere product of the other. This equation never lasts, however. Soon always he goes "a step farther" into the matter and we see it is the "energy" which is the really real. It is the "energy" which underlies everything else, mind included, and the "energy" therefore which truly matters in therapy. Mind is completely reduced to body. Mind is even reduced to a *single simple aspect* of body, the energy flow.

It is interesting to speculate upon the effects of this way of thinking on Reich's evolution as a therapist. When Reich first began working with the body (around 1933) he advocated an integrated mixture: some verbal work with "character analysis" combined with some direct physical work. His intention at that

point was to deal in depth with both levels. But as the years went by he altered his style radically. The "character analysis" became more and more abbreviated; therapy time was given increasingly to physical work.

By the end of his career the "character analysis" had practically disappeared. He was working then almost exclusively with the body.⁸ Sharaf, who was in therapy with him then, describes his (i.e., Reich's) impatience in the sessions when one sought to engage him verbally, his reluctance to discuss even the most pressing verbal themes.⁹

From the point of view of his own model, however, this shift makes perfect sense. Why waste time with all that blah-blah-blah if the really real is the energy alone? Why not go straight to the heart of the problem: blocks and flow? Reich's later clinical style fits quite logically with the most basic tenets of his model.

Let me emphasize, however, that this reductiveness was already present in the model itself in the 1930's. As for technical practice, I naturally much prefer the 1930's Reich to the 1940's Reich. In the 1930's, when he was just beginning to add work with the body, there was still a more balanced weighting of time given to physical as opposed to time given to verbal work. Nevertheless, the theoretical framework which he was then shaping already suffered from the reductiveness I have just described.

⁸What perhaps most remained of "character analysis" was Reich's late bodily work with the eyes, as Boadella (1993) has perspicuously commented. In that context he undertook to explore defensive aspects of the patient's eye contact with the therapist.

⁹ Sharaf's (1983) biography, based in part upon interviews with many persons who knew Reich, is very helpful for forming an objective picture of how Reich actually worked with his clients.

Even if Reich had never changed his clinical style this discrepancy would have remained. As would have the other drawbacks I am listing here.

3. *It easily leads to an overemphasis upon catharsis and/or gratification.* Here is how that can happen. The main goal in each session, if one follows the model, is that blocked energy be released. But what then is the outward sign of release? How does the therapist know he or she has succeeded?

One sign, in principle, could be that the patient reports more kinesthetic sensations of "flow". Another could be that the therapist sees physical indications, e.g reddening of the skin, fibrillation, or the like.

But in practice this is seldom what happens. These results, if they are all that occur, are hardly very significant. So, quite naturally, both patient and therapist expect something more. The release needs to be "deeper" than that indicated by these signs alone. So what then is going to be taken as the criterion of a deeper release?

Depending upon the therapist there will usually be one of two solutions to this problem. The first (and most frequent) is that an emotional catharsis is regarded as the sign of release. The stronger the catharsis, the better. The intensity of emotional expression is thought to reflect the amount of increased energy flow.

The second solution is that the patient state of well-being at the end of the session is taken as the sign of release. The more pleasure and expansiveness he is then experiencing, the deeper and more effective the energy movement is thought to have been. An emotional *expression*, in the cathartic sense, may or

may not have occurred; that is incidental. Feelings of gratification have replaced catharsis as the criterion of therapeutic success. (There are also some therapists who expect both: catharsis followed, at the end of the session, by feelings of gratification.)

I have already discussed how, from my point of view, too strong an emphasis upon catharsis can make the therapy somewhat one-dimensional (chapter 7). As well as how too strong a push for gratification can lead to a collusion to evade other themes and processes -- frustration, sustained mourning, negative transference, etc. My point here is another one: that the energy model naturally lends itself to excesses in either or both these directions.

4. *It tends to narrow rather than to open up body experience description.* This may seem like an inconsequential matter, but in fact it is extremely important.

A problem in all therapy, and a major one in body psychotherapy, is that words capture our body experience poorly. The patient tries his best to convey to the therapist, and to himself, what he is actually apprehending. But often he finds himself at a loss -- where are the words? He searches, he gropes.

Not infrequently that means he has to resort to metaphor. "What I am feeling now is like...it is as if...", etc.. He must delicately let language wash over him. This requires a special attentiveness, and patience.

The energy model here only gets in the way. A patient who has been strongly encouraged to think about her body experience along those lines will much more frequently announce, simply,

e.g., "I feel more energy." Or, "the energy in my right leg is moving." Or, "I think the energy is blocked there." Period. No searching. No quiet struggle. No trying to bring language and experience to a more exact fit.

In reality, however, very little is communicated by this kind of energy talk. I learned long ago to teach therapists in training that, whenever a client reports feeling "energy," it is time to ask a few further questions. To ask, in other words, something like "more exactly, what is it you are experiencing?"

The answers turn out to be quite diverse. One patient perhaps means that he is feeling lively, awake, alert. Another, that he has discovered a sensation of warmth somewhere in his body. A third, that one body part, say a leg, has a restless impulse to move. A fourth, that he is experiencing a kind of tingling. A fifth, that fibrillation -- shaking -- is starting up in his body. A sixth, that one limb is now filled with a light, floating sensation, as if it were about to rise from the mattress. A seventh and an eighth will come up with still other types of report.

In learning to become more aware of the body, and to communicate that awareness, we need all the help we can get. Both ventures are difficult. Especially we need to open ourselves to the richness of metaphoric language. The energy model instead tends to flatten the patient's phenomenological descriptions. It tends to banalize. It provides the patient with a ready-made discourse which frequently is too superficial for the task at hand.

5. *It trains the patient to create a false hierarchy of value with respect to his or her body sensations. This is a*

problem akin to the previous one, but not quite the same.

When the energy model is in the air the client soon gets the idea there is a "right" thing she should be experiencing: energy movement and flow. The rest of what goes on her body she may then subtly disqualify. Some body sensations become just body sensations, so to speak; whereas others are a perception of the "energy." Implicitly or explicitly the therapist is likely to agree.

From my point of view that is to impose a grid of false evaluations. And this in turn is to collude with one of the major barriers to our becoming more aware of our bodies: a tendency to fuse together sensory discrimination with a kind of running evaluative commentary on what is sensed.

What we need in our body psychotherapies is not a reinforcement of this pernicious inclination but help getting out from under it. The zen meditation tradition seems here much wiser. One must learn (you could call it an unlearning) how to feel without at once ranking, how to sense without at once judging. Body experience should be allowed to develop without being instantly segmented into "the right thing" (i.e., energy flow) vs. "not quite the right thing."

6. *It creates a major therapeutic goal out of what deserves to be a minor one.* Liveliness and vitality: these are taken to be the chief aim. Everything else is taken as subordinate.

I am all for liveliness and vitality. May each of us reach her/his maximum possible. But as central goals (both for therapy and for life itself) they are a bit thin. A person can have impressive vitality yet have shallow relationships, for example; or communicate in confusing patterns; or display self-destructive

behavior; etc. There is much more to therapy than building up a capacity for states of excitement.

One might try to counter this criticism by asserting, e.g., that a highly energetic person who has shallow relationships somehow lacks "real" vitality. That seems only a semantic evasion of the issue, however.

Perhaps what is more important, an increase in vitality will occur in body psychotherapy *almost by itself*. In a funny sense it is an inevitable by-product of work with the body. Which certainly is a plus. Yet for that very reason we have even less need to adopt it as the central therapeutic goal. There is so much else which requires attention, with every client.

This summarizes the difficulties I have with Reich's energy model.

One could acknowledge these difficulties, or some of them, and still try to salvage the energy model. This would require introducing changes, modifying Reich's position on one issue after another, etc.

In point of fact, a certain number of contemporary body psychotherapists have chosen that path. They have tried hard to preserve the best of Reich and yet find solutions to the internal problems of his model. And in some cases this has led to valuable new contributions. (For examples see the next chapter.)

My own feeling however is that this is to take on a burden which which we can do without. Inevitably the model's worst problems -- its mechanistic and reductionistic qualities, in particular -- tend to reappear no matter how much tinkering one undertakes. It is an unwieldy model in the end. Poorly mirroring the structures of our existence, it posits a body devoid of

subjectivity. Exactly what is crucial to an understanding of embodiment is thoroughly lost: the intentionality (i.e., being directed outside oneself¹⁰) and agency which characterize embodied mind. Body psychotherapy has everything to gain by building upon other foundations.

¹⁰I here mean intentionality in the phenomenological sense: thinking is always a thinking of something, sensing a sensing of something, etc. For a good discussion of the concept of intentionality as it has been elaborated in the phenomenology tradition see Dreyfus (1991).

Chapter 27

OTHER SCHOOLS AND METHODS

With regard to the general development of body psychotherapy we are in the middle of an innovative, fertile period. New methods and approaches abound. Three decades ago there existed only several distinguishable currents. Now one can find dozens and more dozens. Taking Europe and North and South America together, I would estimate that, at the time of writing this book, there are being practiced and taught upwards of a hundred variations.

Rather than try to describe this entire panorama I will here mention only several approaches of particular interest. This should nevertheless give the reader a feeling for the liveliness and diversity of today's body psychotherapy landscape.¹

Most of the following methods are ones with which I have had some kind of personal contact -- i.e. opportunities to observe or supervise the form of work being practiced. I have limited myself here to methods for which there exists some kind of sup-

¹For more extensive surveys see Boadella (1990) and Meyer (1986).

porting literature to which the reader may be referred for further information.

Bioenergetic therapy has been developed by Alexander Lowen (1958, 1967). Arguably the most influential body psychotherapist alive today, Lowen was originally a student of Reich. Later, dissatisfied with the Reichian methodology, he introduced several major changes.

One proved so effective it has now been adopted by almost every other body psychotherapy school. Reich worked almost exclusively (when working physically) with his clients lying down. Lowen went on to develop a large repertoire of physical techniques for a patient in a standing position.

He has his patients lie down too. But the majority of his bodily interventions are designed for the standing position. Lowen calls such work "grounding" -- i.e., it addresses the relation of the patient's body to gravitational stresses. Elsewhere (chapter 7) I have categorized such techniques as having do to with the re-organization of "vertical alignment".²

During recent years bioenergetic therapy has been subjected to some strong criticism in the wider body psychotherapy world. Two general complaints are often made. In both instances, however, my own perceptions are somewhat different.

The first is that Lowen's style of intervening with the body

² Lowen's (1958, 1967) theoretical account of grounding accords with that description but adds some assumptions (to my mind questionable) about esoteric energies. Energy is said to flow down the legs and into the ground and then back up from the ground into the legs again, etc. While rejecting some of Reich's practices Lowen has retained more or less intact Reich's basic concept of energy.

is too forceful and too cathartic.³ I disagree. There is certainly a truth to this critique if one considers how Lowen was working a number of years ago, when his method first became popular. But having had some familiarity with his work for over twenty years, I would point out that his approach has undergone constant evolution. The version existing today is considerably more nuanced. In addition, many of his colleagues have developed variations of bioenergetic therapy which, while retaining the core of Lowen's original approach, embody a range of different individual styles. Some of these variations include considerable work at the "soft" end of the hard/soft body-work spectrum.

A second frequent complaint is that, when assisting clients to make sense of their childhood past, Lowen relies too heavily on oedipal explanations.⁴ Again I disagree, at least in part. Unquestionably Lowen leans that way. And in doing so, he gives less attention to the preoedipal period than has been recommended, for example, in the present book. Nevertheless Lowen's perceptiveness about oedipal issues and his refusal to shy away from them I find one of his great strengths. Doing supervision I have seen over and over how easily body psychotherapists can collude with their clients to avoid a thorough confrontation with the oedipal past. Patients require extensive investigation of both levels, preoedipal and oedipal. With respect to the latter there is much to be learned from Lowen.⁵

³See for example McNeeley 1987, p. 52; Moser 1989, p. 48; Petzold 1988, p. 381, p. 402; and E. Smith 1985, p. 23.

⁴See for example Pasini in Pasini & Andreoli, 1981, p. 274.

⁵Nor does Lowen entirely ignore the preoedipal. In fact he was emphasizing its importance for some patients long before that point of view became widespread among object relations therapists (e.g., Lowen 1958).

From my own perspective, however, I would advance a criticism of a somewhat different nature. Much as I value Lowen's work I see a fundamental dilemma. This concerns the basic relationship which is established in the therapy between exploration of the body and exploration through language.

Once embarked upon a piece of work with the body Lowen more or less puts language to one side. The patient's language, that is; Lowen himself speaks quite a bit. As opposed to letting the patient find his own insights, and as opposed to offering a context where he discovers his own words too, Lowen instead provides a kind of running commentary. He tells the patient what, in his opinion, the different body reactions mean⁶; he tells what he sees as their connections to the past; he even tells what affect ought next to emerge; and, if then it emerges, what it signifies. The flow of language is mainly therapist-to-patient.

I see this reduced space for the patient's word as a regrettable loss. The patient receives little encouragement while working with the body to find out about himself as a "body-language" entity. And he is given little therapeutic opportunity to build up what I have earlier in this book described as a special skill: staying closely in touch with the body and, out of that closeness, allowing language to emerge. This of course often requires a slower, more patient, more open-ended process. But it renders work with the body a resource even more valuable than otherwise.

⁶Much of Lowen's discourse consists of elaborations of how he views the patient's "character" -- i.e., his fixed personality patterns, especially the more defensive ones. On the level of content these observations often seem helpful and interesting. The point I am making here concerns rather the interactional process between therapist and patient.

Despite this limitation, Lowen has transformed the heritage he received from Reich in numerous positive ways. It should be added that Lowen has transmitted his work to many persons, and that some of his colleagues have produced theoretical writings of value in their own right. Noteworthy in the light of the themes of the present book, for example, are contributions by Lewis (1976), R. Hilton (1980), V. Hilton (1988), Moselli (1988), Peck (1987), and Tonella (1987). Former colleagues who have gone their own way also continue to add to the bioenergetic literature. Pierrakos (1976) puts a stronger accent than Lowen on ideas about the body to be found in Oriental sources. Muller (1984), Berliner (1986) and Kirsch (1986) emphasize concepts drawn from Winnicott and Kohut.

Stanley Keleman over the course of many years has fashioned a highly original form of body psychotherapy (Keleman 1979, 1987). The core of his work is a series of subtle verbal interventions which require the patient to explore his body defenses in fine detail.⁷ With time and with repetition these interventions help the client become more aware of his body. They also demonstrate to the client how his body defenses structure interpersonal contact. To some extent chronic muscular constrictions can even be loosened through this awareness process. The body is re-organized from within, so to speak.

Transference is also addressed in the therapy, explicitly and frequently (Keleman 1986). As I have already pointed out, that is too seldom the case in body psychotherapy methods.

Keleman has developed as well a system of diagnostic body

⁷In other words they are a form of what I have called internal techniques (chapter 7).

types (i.e., body appearance is correlated with personality characteristics). Resembling somewhat Lowen's "body reading," this system stands (as does Lowen's) in a tradition going back to the eighteenth century and whose more modern manifestations include Kretschmer (1925) and Sheldon (Sheldon, Stevens & Tucker 1940).⁸

The late Magda Proskauer developed a work which deserves to be more widely known. Proskauer as a young woman studied with different teachers during the great wave of German body awareness disciplines which followed on the heels of World War I (c.f. chapter 19). Eventually she migrated to the U.S.A.

Her approach was built around a delicate but profound work with breathing (Proskauer 1968). The patient quietly explores his immediate respiratory patterns in a manner more akin to Zen meditation than to the mobilization techniques found in most body psychotherapies. This leads to a heightened awareness of the most minute body sensations. At the same time the patient is encouraged to be attentive to other inward phenomena, and particularly images. Subsequent to this immersion in special body states the images are discussed with the therapist. Associations are generated rather as if they were miniature dreams.

⁸As too is the case with Lowen, Keleman's diagnostic system is based upon personal experience and intuition rather than any substantiating research.

The question of correlations between personality and body structure greatly merits solid research. When Sheldon's (1940) work (an attempt at empirically researched body/personality correlations) was first published there was a spate of additional studies, some confirming and some disconfirming Sheldon's findings. Then interest died out, leaving the entire matter in an inconclusive state. It is obvious that improved technology together with today's better understanding of research design could permit much more sophisticated undertakings in this area.

Helmut Stolze has brought together a set of techniques whose roots also go back to Germany between the wars. The emphasis of his *Konzentrativen Bewegungstherapie* is upon a pure sensing of body sensation and movement (Stolze 1984, Becker 1981, Gräff 1983). Little immediate work is done with emotions.

Currently used in a number of psychiatric and psychosomatic clinics, this approach is normally undertaken in group settings and is seen as an adjunct to verbal psychotherapeutic treatment. The KBT therapist stays alert to psychological issues, however. The groups are guided through a series of structured, closely monitored body experiments, with frequent opportunities for members to share with and report to one another what they have experienced.

An interesting variation of this work has been developed by Richard Meyer (1982, 1986), who combines KBT with techniques drawn from other body psychotherapy methodologies. Meyer, who brings more active work with emotion into play, uses his approach in individual as well as group therapy settings.

Albert Pesso has created an especially innovative form of body psychotherapy. A former dancer, Pesso (1969, 1973) works extensively with movement. The therapy takes place in a group setting. A patient explores movement impulses connected with wishes, emotion or body sensation. The leader then helps one more or other group members provide answering movements, the nature of which is determined by the patient himself.

From this typical beginning point a kind of movement-oriented psychodrama tends rapidly to develop. Intense, highly charged regressive states can quickly occur. To manage these regressive states the therapist actively introduces new steps in

the group scenario. A "symbolic" (i.e., through representative body actions in interaction with other group members) satisfaction of underlying early needs and desires is encouraged.

In addition to Pessó's own writings good discussions of his work can be found in Moser (1989) and Roth (1991).

Reichian therapy in its post-Reich forms can be found today in many variations. Rarely will one find it practiced strictly as Reich did, however. The shortcomings of Reich's original approach, it is generally agreed, are too extensive to ignore.⁹

Usually this has meant an introduction of new elements on both the verbal and the body levels of the therapy. A particularly rich version is represented by the work of Boadella (1987). Especially on the level of physical technique Boadella has successfully brought together innovations from many quarters, including new techniques of his own invention. Another interesting reworking is that of Rispoli (Rispoli & Andriello 1988), who goes so far as to dispense with Reich's energy model entirely.¹⁰ Influential contemporary Reichian models have also been developed by G. Boysen (1976), P. Boysen (Boysen & Huber 1991), Brown (1990), Kelly (1991) and Liss (1976). Di Marchi (1965) has not only retained Reich's therapeutic approach, but has also engaged himself in a form of critical sociology in the tradition of Reich.

One curious point. There is much that is new and valuable

⁹Exceptions to this opinion are Baker (1967) and Navarro (1984).

¹⁰ One could even question whether what is left in Rispoli's picture is really "Reichian", so much of the original Reich has been eliminated. But doubtlessly this is merely a semantic issue.

in many of the current Reichian variations. But what almost never appears in them is precisely what, to my mind, was Reich's most important contribution -- the systematic work with negative transference developed during his early professional years (Reich 1949).

This was certainly his most lasting influence upon psychoanalytic theory and technique. (Kernberg (1984) for example cites Reich as a major influence upon his own methodology.) It is thus surprising that, with this powerful instrument already so to speak at hand, the contemporary Reichian branchings and subbranchings have not evolved more ways to put it into action. I suspect that in the coming years we may see more attention turned to this rather neglected early side of Reich. If so, the result is certain to be a further enrichment of these Reichian modalities.

The "...and the body" combinations. Name almost any general therapy form and somewhere there exists an "...and the body" mixture. Jungian body therapy, Transactional Analysis body therapy, etc. Practically every permutation possible.¹¹ In some cases the "integration" belonging to these mixtures leaves something to be desired. Nevertheless many of them contain useful and creative new advances.

Interesting writings on Jungian therapy combined with a physical approach include Conger (1988), Grof (1975), McNeely

¹¹Even behavior therapy and the body. Once over a period of time, as a consultant for the University of Munich psychotherapy clinic, I helped a number of the staff integrate work with the body into what had until then been a classic behavioral modification approach. The model they eventually evolved consisted of (a) a prior treatment phase focused upon symptom removal/amelioration, followed by (b) a longer phase working with both transference and the body.

(1987) and Stepski-Doliwa (1989). On Transactional Analysis and the same, Cassius (1980), Cornell (1992), Erskine (Erskine & Moursund 1988), Growell (1975), Fourcade and Lenhardt (1981), Ligabue (1991) and Waldekranz (1993). On Rogersian therapy and the same, Ariano¹², de Marchi (1984), and Moselli (1988). On Adlerian therapy and the same, Heisterkamp (1993).

The late Jay Stattmann (1989) put together physical interventions with therapeutic work with guided imagery. Aalberse (1991) and Marlock (1991) provide stimulating discussions of Stattmann's work.¹³ Erdmanis (1987) has integrated physical techniques with psychodrama. Gammer (1992) and Rosenberg (1994) have introduced work with the body into couple and family therapy. I have also developed some ways to intervene with couples and families.

A combination which I am amazed has not been more widely developed is that of hypnosis "and...". Induced trance states have so many similarities to certain of the states of consciousness often appearing during work with the body. A number of body psychotherapists occasionally use a hypnosis technique, but a more extensive integration would surely be possible. Levine's (1992) fine work is an example of its potential. Brinkman (1989), in a more limited fashion, combines Rolfing with

¹²Giovanni Ariano, unpublished manuscript. The work of Ariano and his colleagues in Naples is also of special interest because of their extensive work with psychotic and borderline patients. C.f. also Ariano's (1986) discussion of body schema and diagnosis, as well as his critique (1990) of Rogers.

¹³Aalberse, drawing strongly upon James Masterson (1976), has extended Stattmann's approach by adding elements of object relations theory.

Neurolinguistic Programming, the latter being a mode of hypnosis.

At times the mixing is so eclectic one is at a loss to categorize the result. Steve Johnson (1985, 1987, 1991) ingeniously brings together techniques from about every existent form of humanistic psychology; elements from behavior therapy and psychoanalysis find their place in his approach too. Kurtz (1990), Marcher (Bentzen, Jorgensen & Marcher 1989) Mindell (1982) and Petzold (199) also combine physical techniques with a wide variety of other methodologies. Marcher and her colleagues have brought a valuable attention to the treatment of Post-Traumatic Stress Disorder. Kurtz, Mindell and Petzold are quite innovative not only with techniques, but also with what I have elsewhere called the "weave", i.e., how one intertwines physical and verbal work. Petzold's writings should be noted as well for their productive engagement with many theoretical issues.

Some of the most fertile "and the body" contributions have been made in the realm of Gestalt therapy. That is not surprising. Perls (the founder, or at least one of the principal founders, of Gestalt therapy¹⁴) was at one time Reich's patient.¹⁵ Also, during both his New York and California periods, Perls kept up an extensive contact with body awareness disciplines (e.g., with the work of Charlotte Selver). As a consequence, already in Perls' time the technical focus of Gestalt therapy included a pervasive attention to bodily sensation and movement.

¹⁴In contemporary Gestalt therapy literature Laura Perls and Paul Goodman are also frequently cited as having made significant contributions to its development.

¹⁵During Reich's Berlin years. This was slightly before Reich began working actively with the body. But he had already begun frequently to draw his patients' attention to posture, gesture and bodily mannerisms.

Direct physical techniques can therefore rather easily be added to the Gestalt fabric. They function as a sort of natural extension, making the problem of integration less knotty than is the case with other therapy methodologies. James Kepner's excellent *Body Process* (1987) is a good example of the rapidly growing "Gestalt and the body" literature. Also to recommend are Lobb and Salonia (Salonia 1988), Maurer (1987), Rosenberg (1985), and Smith (1985).

I hope this short glimpse conveys something of the sheer variety of present-day body psychotherapy approaches. As I have said, in addition to the ones cited here there exist plenty of other schools and methods.

What will the coming years bring? This is difficult to predict. On the one hand, it can easily happen that a therapy form becomes one day so codified, so accepted and "understood", that the impulse toward inventiveness and creativity dies away. As regards body psychotherapy, many social and cultural factors will unquestionably work in that direction. Societies are innately conservative in permitting change at the level of our relations to our bodies. They also have a vested interest, as Foucault (1977, 1978) has shown, in monitoring and shaping any such change which does occur.

On the other hand there is the factor of the body itself. Here is the wild card in the deck. However codified, body psychotherapy will always find itself face to face with this more primitive dimension of our existence, and not just with language alone. It is a dimension full of surprises.

THE PARADIGM OF EMBODIED MIND

In these pages I have tried to show how the paradigm of embodied mind allows us to rethink the place of the body in psychotherapy. A therapist guided by this paradigm will listen to her or his patients differently. A therapist who also uses "body interventions" will do so with different aims, and a different horizon of understanding.

The embodied mind paradigm offers more, however. Some topics I have been able to touch upon only briefly. Three especially would deserve further exploration.

One is a puzzling but fascinating philosophic conundrum. What is the relation of embodied subjectivity to its supporting neurophysiological base? What ways of thinking, what ways of speaking, might best grasp the elusive nature of this tie/border? The more researchers learn about the brain, the more "the problem of consciousness", as it is often called, raises questions both ancient and new. One such question: if consciousness is adequately described as embodied consciousness, to what extent, and how, does this reframe the task of giving an account of "the psychophysical link" (McGinn 1991)?

A second issue concerns our understanding of emotion. Important advances have been made in the last thirty years in

what has come to be known as "emotion theory". In part this exchange has taken place among philosophers. What is emotion in the first place? What are its functions, its purposes? What are the implications for our lives? Such themes have been productively brought to the foreground by Solomon (1976), Neu (1977), A. Rorty (1980) and a number of others. A lot of new research by experimental psychologists has been focused upon the same themes, emotion in this domain as well having become a recent subject of interest (c.f. Frijda (1986), Lazarus (1991), Oatley (1992)). To some degree the experimental research has been influenced by the philosophic writings, and vice versa. Emotion theory has become truly an interdisciplinary site.

Yet from the point of view of the present book there is a gap. This is a fuller comprehension of the role of the body in emotion. What Solomon and others have chosen to analyze, and with considerable success, is affect's cognitive dimension. Our emotional states, it is claimed, allow us to evaluate the world by means of special "cognitive appraisals".¹ I would certainly agree. Yet the empty space in this picture is the body. Among the philosophers the body is little mentioned. And among the experimental psychologists, who also study mainly this cognitive aspect, the situation is close to the same. Either the body is overlooked; or it is considered only from the perspective of its biochemistry and neurophysiology²; or, at the most, it is photographed and videotaped in its expressive movements (and these

¹For example, who is angry judges the world as manifesting unjust action towards him.

²Extensive research has also been undertaken into the biochemistry and neurophysiology of emotion. These investigators tend to preoccupy themselves very little with the experimental psychology research, however; and vice versa. A notable exception is Le Doux (1989). Interestingly, Le Doux's hypotheses about the neurophysiological underpinnings of emotion fit quite well with the notion of affectmotor schemas

usually with respect to facial expression alone³). Left out almost entirely is our bodily experience of emotion; the nuances of choice in that experience; the interplay of breathing, of body defenses, of motoric exploration of feelings; and much more along these lines. A richer view of embodied subjectivity would surely permit a valuable expansion of emotion theory (Downing 1994).

Such an expansion would also have many ramifications for psychotherapy. Worth adding is that it might most benefit a notoriously difficult area of psychotherapy: the treatment of psychosomatic disorders. (The term refers, primarily, not to hypochondriac patients who think they are physically sick when they are not; but to patients with genuine somatic symptoms -- colitis, ulcers, asthma, muscular pain, etc. -- the causal determinants of which are guessed to be psychological as well as physical.) Huge numbers of such patients are now turning up in every country which has a developed system of mental health institutions. Yet good conceptual frameworks for this physical/psychological symptomology mixture are next to non-existent. The embodied mind paradigm, if taken together with a correspondingly developed emotion theory, holds great promise for this field (Downing 1994). And all the more when supplemented, on a technical level, by psychotherapeutic work with the body.

Lastly, gender. How do men and women live their bodies differently? And what, individually and collectively, are the options for change and transformation? I have proposed that many gender differences in bodily experience, as well as many differences in how the body is used to structure one's world, are likely more cultural than biological. Some of the most interesting writings in recent feminist theory have taken a similar point of view. But if this is true, are there, realistically speaking,

other alternatives for human embodiment? The more years I work with the body, the more I suspect there are, and should be.

Granted, inherited body traditions have tremendous tenacity. And they mostly play their game far from consciousness. We live them out, the man tribe its versions and the woman tribe its versions, with an invisible pervasiveness, like the oxygen we inhale. The multiple component threads of these traditions lack language, they "resist representation" (Scarry 1994). (Hence the resort to metaphor by thinkers such as Irigaray (1985).) Yet from that it does not follow we should refuse to problematize them. Where, how, by what means might these bodily traditions be better delineated? How might their many components be more consciously experienced, be weighed, sifted and evaluated, be otherwise inflected (Butler 1993), be otherwise recombined? What are the alchemical possibilities? Everyone feels instinctively he or she has no choice here. But that is our collusion. Scratch the surface and there is choice.

Our embodiment is given to us, historically, as a gift, a burden, a prison, and a crossroads of opportunity. Each of these meanings must be acknowledged. No one of them should be allowed to mask the others.

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